

Confronting Ableism: The experiences of employees with bipolar disorder within ‘normative’ work contexts

Kehinde Olowookere

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School of Social Sciences

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Abstract

In contemporary, westernized and industrialized nations, such as the United Kingdom, paid work is considered the foundation of political, economic and social order (Newton et al., 2007). As vital as it is, however, paid work/employment remains an area of disadvantage for individuals who are constructed as ‘different’, such as women and disabled individuals. Disabled people, in particular, have been found to experience exclusion and discrimination in the labour market. This is evidenced in employment indicators, which depict an uneven distribution in employment outcomes for disabled individuals, particularly those with mental health conditions. The reasons for these disadvantages remain the essence of substantial dissension. The current study aims to contribute to knowledge of why disabled employees, specifically those with bipolar disorder, may be disproportionately subjected to discriminatory attitudes and practices in the workplace and labour market. The overarching aim is to offer a theoretical background for understanding the experiences of employees with bipolar disorder in the workplace.

The study conceptualizes disability as a social construct discursively produced within social relations. The research is informed by qualitative semi-structured interviews with individuals who have bipolar disorder, allowing for a detailed exploration of how participants interpret their work experiences. The data collected was analysed using narrative and Foucauldian analytical techniques. Fundamentally, the findings offer a nuanced and in-depth perspective on the experiences of a concealed, yet marginalized identity in the workplace. The insights gained point to how the experiences of work may be a product of the construct of work around the ‘ideal’ employee. The narratives collected also underscore that the social connotations attached to the label of bipolar disorder, when allotted to participants, constructs such individuals as ‘less capable’. It allows for the dissemination of meaning to participants’ experiences, and opens up positions of subjectivity for these individuals. The findings both affirm and strengthen the theoretical basis of the social relational model of disability.

The study contributes to knowledge of the vital role played by ableist work contexts in the lived experiences of employees with bipolar disorder, a subject area that remains largely under-researched in the domain of work and employment. The particular emphasis on social interactions, and on problematizing work contexts rather than individual capability differentiates the study from previous studies on bipolar disorder, and generates pertinent considerations for disability studies. Essentially, the findings call for the modification of work to comprise inclusive strategies, which are suited to the individualities of employees. The implications, both for employees and employers, are wide-ranging. The analysis of the resistance of subjective positions in the study adds to knowledge of how the disadvantaged position of disabled employees can be confronted and altered. The findings also highlight the need for a shift in organizational and governmental policies/schemes from individualizing disability to querying the normative nature of work in contemporary workplaces. As such, the study does not only offer a nuanced analysis of the lived experiences of employees with bipolar disorder; it also offers suggestions on how prevailing discursive practices can be made accommodative of difference.

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Research Thesis Submission

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School/PGI:	Social Sciences		
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List of abbreviations

BPD:	Bipolar Disorder
MHC:	Mental Health Condition
CMHC:	Common Mental Health Condition
HRM:	Human Resource Management
WHO:	World Health Organization
ILO:	International Labour Organization
RTW:	Return to Work
UPIAS:	Union of the Physically Impaired Against Segregation

CHAPTER 1 Introduction

1.1 Introduction

In contemporary, westernized and industrialized nations, such as the United Kingdom, paid work is considered the foundation of political, economic and social order (Newton et al., 2007). It influences the conference of status on individuals, with prestige given based on the type of work people do, and how successful they are at it. As vital as it is, however, work/employment remains an area of disadvantage for some people, particularly those considered ‘different’, such as women and disabled individuals (Pless and Maak, 2004). Employment indicators depict this uneven distribution in employment outcomes as parallel with a range of individual qualities termed as deviations. Hence, individuals considered different with regards to ability, age, gender or race often experience marginalization in the workplace (Radermacher, 2006). The majority of these facets of ‘difference’ are currently acknowledged in literature/practice. Ableism, however, remains largely under-researched, and disability remains absent in diversity studies (Davis, 2011). Individuals that fall into the ‘disabled’ category, nevertheless, experience particularly high levels of inequality, both in the labour market and workplace (Marwaha et al., 2013). The reasons for these disadvantages remain the essence of substantial dissension. The current study aims to add to knowledge on why disabled employees may experience disadvantages in the workplace and labour market, allowing for possible intersections with other marginalized positions, particularly gender. Emphasis is on bipolar disorder (referred to as BPD), a largely under-researched mental health condition (MHC) in the domain of work, employment and Human Resource Management (HRM). The study takes the position that if employees with BPD, who have been constructed as ‘different’ from standard norms, are to be fully included in the workplace, it is vital to understand and analyze the lived experiences of BPD in the workplace. The study, therefore, examines the experiences of BPD employees, and investigates how constructions/conceptualizations of the condition in the workplace impact on employees’ subjectivities. The current chapter offers an outline on how this will be accomplished. The chapter serves as an introduction to the

study; it essentially explores the background of the topic and places the study within the context of existing research on disability.

First, the chapter explores the key themes that form the basis of the thesis, relating these to current interpretations of MHCs in the workplace and the society at large. Subsequently, the particular subject area being researched is delineated, and previous considerations of the topic are examined alongside the significance of researching BPD. The research aims and objectives are then outlined, while the final part of the chapter sums up the structure of the thesis. It is vital to note that given the rarity of research on BPD in the workplace, the discussion in this thesis is widened to include MHCs and disability in general. This further underscores the significance of the topic being researched.

1.2 Mental Health

According to the World Health Organization (2003), mental health does not merely connote an absence of MHCs, it is medically delineated as a state of health where people are able to identify their capabilities, can handle the standard stress experienced in work/life effectively, and can add productively to their society (World Health Organization, 2003). Several conditions are perceived as possible restrictions to this state of health. These conditions range from those termed Common Mental Health Conditions (CMHCs), such as stress and anxiety, to more severe ones including BPD and schizophrenia (VicHealth, 2007). The focus of this study is on one of the more 'severe' forms of MHCs, namely BPD.

1.2.1 Bipolar Disorder

Like any feature of the self, such as attention, literacy or sociability, human moods are perceived to exist along a continuum that runs from mania on one end, to depression on the other (Armstrong, 2010). There are several moods and temperaments between the two poles, which anyone would usually experience. However, individuals with BPD are medically delineated as those who experience moods which tend to be more intense, and could sometimes result in what appears to the untrained eye as unpredictable behaviour (Armstrong, 2010). It is, thus, said that people with BPD typically move from one

extreme end of the continuum to the other. The term BPD, itself, symbolizes a range of conditions along the continuum, all having similar features with regards to feelings of elation and depression; with ‘bipolar’ connoting the two extremes of depression and mania (Clark and Chambers, 2007). The highs (manic episodes) are characterized by an elated emotional state, accompanied by feelings of petulance, distractibility, excess libido, hyperactivity, impetuosity and grandiosity (Laxman et al., 2008). The lows, on the other hand, (depression episodes) are characterized by suicidal intents, violence, apprehension, guilt, lassitude and desolation (Laxman et al., 2008). The frequency of the episodes is used as the basis for determining the severity of the condition, and the type. Other conditions also exist along the continuum with no precise definitions (Cox et al., 2014).

Principally, the condition remains unknowable, with no regular distinguishable characterizations (Nemade and Dombeck, 2016). Consequently, people are often misdiagnosed. Diagnostic measures have, nevertheless, expanded overtime, and this, along with the continued emphasis on mood variations, has led to a situation where an increasing number of people fall under the BPD scope. According to Linklater (2013), the continuum for moods has become broad enough to include nearly anyone who experiences ‘lows’ or ‘highs’. As a result, there is an increasing prevalence of BPD. The next section considers the prevalence of BPD and MHCs in the UK.

1.2.2 Prevalence of Bipolar Disorder

According to Bevan et al. (2013), almost 450 million individuals currently live with MHCs in the world. These conditions are responsible for about 20 percent of the impairments in Europe (Knapp et al., 2007). In the United Kingdom, it is projected to be one of the major sources of impairment, as it contributes up to 22.8 percent of the number of people with impairments, much higher than 15.9 percent for cancer, and 16.2 percent for heart diseases (Department of Health, 2011). The most prevalent MHCs are the common MHCs (CMHCs). Stress, for instance, is considered one of the major contributors to lost working hours (Frost, 2012), and a major source of longstanding absences from work. Depression is also quite predominant. According to Pomaki et al. (2011), anxiety and depression are amongst the most prevalent CMHCs globally. Over

150 million people experience depression, with approximately a million committing suicide annually (World Health Organization, 2003). Severe MHCs, while not as prevalent as CMHCs, are increasingly present amongst the UK populace. BPD is said to be one of the prevalent forms of severe MHCs (Galvez et al., 2011). It is also one of the major impairments worldwide; with Gardner (2011) noting that 2.4 percent of the world population have been diagnosed with BPD at some point in their life. There does exist some contention on the prevalence rate of BPD due to frequent mis-diagnosis (Fajutrao et al., 2009). Fineberg et al. (2013), nevertheless, estimate that mood disorders (BPD and unipolar depression) are the fourth major type of MHCs in the UK. This is illustrated in the figure below:

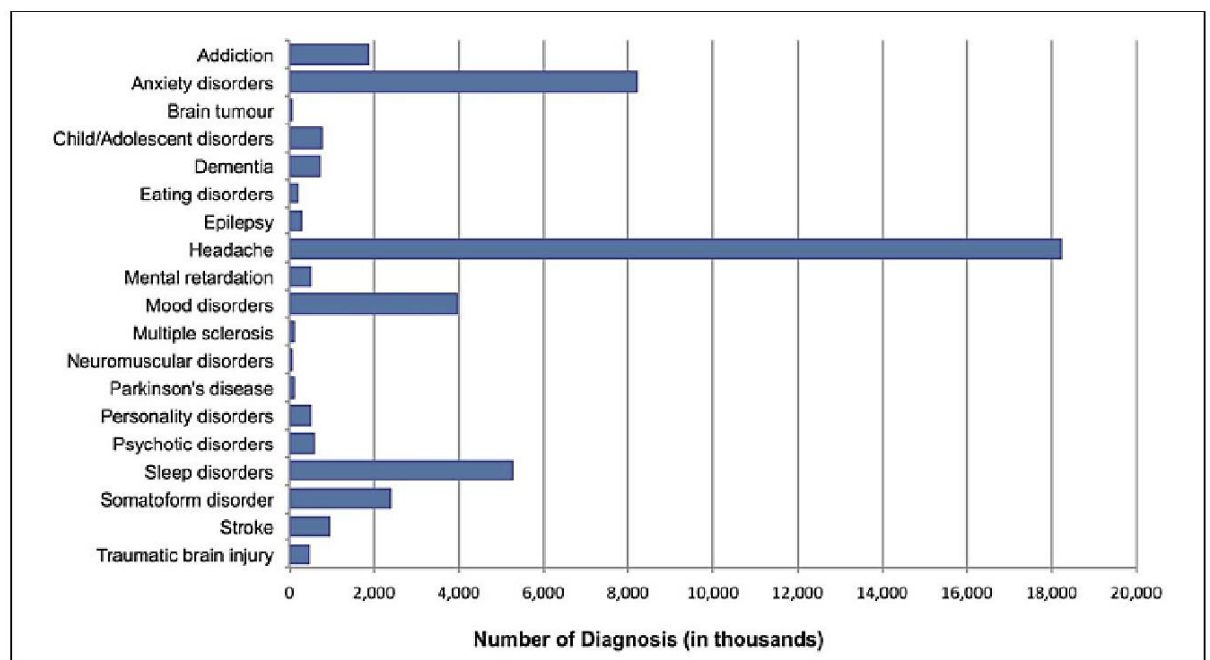


Figure 1.1: Estimated 12-month UK prevalence of MHCs (Fineberg et al., 2013)

According to Fineberg et al. (2013), about 9 percent of the UK populace (3,937,000) have mood disorders (either BPD or unipolar depression). Of these, the combined prevalent rate of Bipolar-I and II is between one to two percent; it is between three to six percent if all conditions on the bipolar spectrum such as hypomania and cyclothymia are included. Aside from the condition itself, suicide, unemployment and co-diagnosis further increase the prevalence of BPD. About 65 percent of individuals with the

condition have a co-diagnosis or an associated condition, the common ones being substance abuse and anxiety disorders (Fajutrao et al., 2009). The increasing prevalence of BPD and MHCs, in general, makes it a valuable area of study, particularly in the area of work, given the disadvantages individuals with the condition seem to experience in the labour market and workplace.

The type of impairment may influence the degree of ableism experienced. Hence, the next section examines the reasons for selecting a particular impairment.

1.2.3 Why BPD?

In purely ‘strong’ social model terms, a focus on a particular impairment would be seen as drawing on the medical model. The social model of disability is known for its strong stance on separating impairment from disability. Core social modellists, such as Finkelstein and Oliver, were not keen to explore phenomena outside of ‘disability’, as they believed it will dilute the message of the social model and divide the ‘united stance’ the model advocated for. Chapter three discusses some of the critiques that have been levied on the model due to this stance, and particularly for what seems to be a disregard for ‘impairment’ within the framework of the model. The majority of the critiques revolve around the rejection of the body in its analysis, the denial of ‘difference’, and the unification of disabled individuals. The portrayal of disabled individuals as a unitary group is perceived by critics as leaving modellists with little room for the exploration of other social identities, such as race, age or gender (Oliver, 2013). Even though the current study adopts a post-structuralist perspective, the study does not deny the body and impairment. Emphasis is, however, naturally on the materiality of discourse. The body is taken to be the product of social practices, and impairment, a ‘discursive construct’. Put simply, language is considered as the medium through which the society makes sense of corporeality; it impacts on how an impairment is understood/responded to, and the resultant experience of the impairment for the individual. Different impairments may, therefore, have different implications for the individual, and engender dissimilar reactions from the wider social/work environment.

The study acknowledges that impairments will be experienced in diverse ways, and the experiences of ‘disability’ may vary on the basis of the impairment, as impairments are constructed and perceived differently. In practical terms, an evident ‘impairment’ could generate specific reactions that an imperceptible ‘impairment’ will not. This relates to the difference noted by Goffman (1963) between what he terms ‘discreditable’ individuals whose impairments are not known, and ‘discredited’ individuals whose impairments are evident and perceptible. Imperceptible impairments may not produce as much ‘disability’ as perceptible ones, particularly in terms of social responses. Their discursive constructions may, nevertheless, impact on the sense of self (Shakespeare and Watson, 2001). Each form of ‘difference’ may or may not have a significant impact on both the person and the social context within which they are located.

Summarily, while social modellers may interpret the sole focus on BPD as emphasizing the medical components of the experience of disability, in terms of accepting a medical diagnosis (Shakespeare and Watson, 2001), it is vital to note that the study does not argue for the separation of disability into components. The study simply maintains that impairments may be experienced in different ways, often times due to the social perceptions of such impairment, the way it is understood, and its discursive construction. A post-structuralist perspective allows for the examination of the role played by discourse in shaping such social responses. This underscores the theoretical stance of the study on the deconstruction of notions of disability as ‘difference’. The next section considers how BPD has come to be regarded as ‘disability’.

1.2.4 BPD as disability

MHCs are delineated as ‘disability’ in the workplace on the basis of the Equality Act 2010 (Lockwood et al., 2012). The Act promotes the equality of opportunity between disabled and non-disabled individuals; and protects anyone with ‘a physical or mental impairment, which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities’ (Equality Act 2010, s6). In addition, the Equality Act covers recurrent or long-term MHCs. The definitions within the Act suggest that individuals with BPD are protected by the Act (Woodhams and Corby, 2003), hence, delineating BPD as a ‘disability’. The language of the Equality Act is often adopted in

work contexts, particularly with regards to negotiating work accommodations as further examined in subsequent chapters of the thesis.

The Act has, however, largely been critiqued for aligning with the medicalized definition of disability. Medical modellers focus on the personal features that impact on employability. These are highlighted as ‘difference’ as implied in the Equality Act’s definition. Opposing definitions were developed by the Union of the Physically Impaired Against Segregation (UPIAS) in 1976, which differentiate between the terms ‘impairment’ and ‘disability’. The Union was one of the first to push disability studies towards the social interpretations that came to be regarded as the social model. They define impairment as either the lack of a limb or part of a limb, or having a defective limb, organ or body system. Disability, on the other hand, is defined as the disadvantages and limitations which occur due to how the modern society has been structured with little or no consideration for individuals with impairments, resulting in the exclusion of such individuals from typical social processes (UPIAS, 1976). These diverse definitions of disability as, on the one hand, pathology within the medical sciences, and on the other, social oppression within the social modeller accounts has resulted in what seems to be a lack of precision regarding the definition of disability. It is common to find the term ‘disability’ being used in contemporary society to connote both the UPIAS definition of disability and impairment itself. Disability, therefore, continues to be a disputed conception, and addressing the question of when an individual becomes regarded as disabled may not be entirely clear-cut. It raises epistemological and ontological issues, as further discussed in Chapter three.

This study returns to the UPIAS definition of disability as the disadvantages and limitations which occur due to how the modern society has been structured, and extends it to a social relational understanding of disability as occurring due to socially imposed restrictions, an indication that disability relates to the ‘imbalanced’ social relations that occur between individuals perceived as different and those perceived as ‘normal’ (Reeve, 2004). Impairment is taken to be the facet of the body that has been socially constructed as ‘deviance’ which shapes social interactions (Thomas, 2004b). Essentially, the study delineates disability as resulting from the notions of ‘difference’

which are produced via discourse, and become imprinted on subjectivities within social interactions. Hence, even though BPD has been defined and delineated in order to offer some context for understanding the MHC being studied, the study is not concerned with the definition of BPD. Rather, the study queries the definition of the condition, and considers it a social construct (Anastasiou and Kauffman, 2011). In other words, the manner in which BPD is interpreted, and whoever is accordingly given the label, is a function of how the condition has come to be interpreted. A Foucauldian perspective is adopted for analyzing how such constructions become imprinted on subjectivities. Thomas (1999) reasons that this social relational perspective is more suited to understanding disability, and should be employed more in disability studies, as opposed to the perceptions of disability as resulting from impairment or from the environment. She notes that this is a more conceptual reading of the social model.

1.3 Language of the thesis

It is vital to note that language plays a major role in developing and sustaining social notions about disabled individuals. For instance, language has, in the past, been positioned as supporting classism and sexism, and increasingly, in recent times, ableism (Carson, 2009). The same can be said for the language of disability and BPD. The term ‘bipolar disorder’ replaced ‘manic depression’ in the late 1900s; and while this term seems to be widely accepted, the idiom ‘dis-order’ does construct the condition as a ‘deviation’ in relation to ‘order’. It could be termed a value laden word, whereby individuals who receive the label and the people around them take it as an adverse evaluation. This suggests that the term is a stigmatizing descriptor, as it connotes that something is ‘wrong’ with the individual given the label. The term ‘dis-ability’ has itself been said to construct disability as ‘deviation’ in relation to ability. This study deconstructs such binaries, by underscoring the power relations that stem from the subdual of one side of the binary. Disability, rather than being considered dis-ability or in-ability, is taken to be a social construct.

It is, also, vital to delineate the practical use of language in the study. According to Burns (2016), the stance on disability-related language is interpreted in diverse ways in different countries. In the USA and Australia, person-first language is used. This

connotes that the ‘person’ comes before the ‘disability’, that is, ‘a person with disability’. Conversely, the UK adopts the term ‘disabled person’, suggesting that disability occurs due to the restrictions faced within social contexts, which result in exclusion for individuals with ‘impairments’. According to Carson (2009), the phrase ‘a person with disability’ relates the individual to an impairment, and suggests that the impairment accounts for experiences of differentiation, while the term ‘disabled people’ suggests that disability is imposed on an individual. The two forms of language continue to exist, with some contention on the term most suited for demonstrating the experiences of individuals with impairment. Irrespective of terms, ‘disability’ academics acknowledge the vital role played by language in disability studies.

As aforementioned, disability is taken to be a social construct in the current study, the product of social norms and standards. Hence, in line with the UK social model’s interpretation of disability, the study adopts the term ‘disabled employees’, in contrast to the person-first approach of ‘employees with disability’ (Goodley, 2011). This ‘language’ draws a distinction between an impairment and the resulting disability. The social model does allow the use of the term ‘impairment’, where research refers to a condition such as BPD (Carson, 2009). Hence, the study uses the terms ‘BPD employees’ and ‘employees with BPD’ interchangeably. Another vital delineation is the use of the expressions ‘able-bodied’ or ‘non-disabled’. Carson (2009) suggests that referring to individuals with no impairment as able-bodied is indicative of discrimination on the basis of a perceived ‘advantage’. The term ‘non-disability’, on the other hand, is all-inclusive, and infers that disability may affect anyone. This is pertinent given that several individuals with ‘impairments’ are fully functional, and can be considered ‘able-bodied’. The term non-disability is, thus, considered apposite when referring to individuals with no known ‘impairment’. The study adopts this term.

1.4 Researching Mental Health

The increased prevalence of MHCs and BPD in the UK amongst working-age individuals is often portrayed in literature as resulting in vast affective and financial costs, both for the individuals affected and the society (VicHealth, 2007). From a medicalized viewpoint, these conditions are perceived as impacting on the individual

earning power, due to the perceived effects on workability among other things. Organizations are also taken to incur costs due to absenteeism, presenteeism and turnover rates (Frost, 2012). According to Frost (2012), MHCs cost industrialized nations approximately three to four percent of their GNP; while it costs businesses in Britain approximately £26 billion annually. At the national level, the majority of these costs are perceived to result from the payment of disability benefits. Chorley (2014), for instance, posits that the UK spends about £9.6 billion on Employment and Support Allowance, and £13.8 billion on Disability Living Allowance. The percentage of inflows onto disability benefits that are as a result of MHCs is about 40 percent (Irvine, 2011).

Several reasons have been given in research for the supposed ‘costs’, the majority revolving around the perceived decrease in the workability and capability of disabled individuals (Roulstone and Barnes, 2005). Disabled people receive the major part of the responsibility, and have been referred to as ‘lazy’ or morally deficient. Indeed, they have been considered by some as ‘evading’ work, with Britain described as being laid-back, and allowing individuals with MHCs to subsist on benefits (Briant et al., 2011). These notions of reduced capability are comparable to those presented when rationalizing the gendered disadvantages which occur in the labour market; wherein, women are socially perceived as accountable for the disadvantages experienced in the labour market. According to Travis (2015), the notions of incapability attached to gender, and the disadvantages experienced on the basis of gender in the labour market occur due to the individualized constructions of gender found in legislation and policies. Similar perceptions exist of individuals with impairment as less capable than non-disabled peers, which are largely encouraged by the UK government’s tendency to individualize disability, as if it were an individual liability. Alan Johnson (an ex-Secretary of State for Trade and Industry), for instance, once suggested that disabled individuals be made to resume work speedily. He placed the onus on the medical profession (who have been blamed for contributing to the benefits predicament by certifying individuals as unfit to work); stating that medical professionals should aid in ending the ‘sick-note’ approach (Briant et al., 2011). The focus on notions of evasion and individualized difficulties has resulted in the introduction of modifications and

reforms targeted at encouraging individuals on benefits to find jobs, particularly through government-sponsored programmes such as the Pathways-to-Work and Welfare-to-Work programmes. More recently, the schemes being introduced seem largely targeted at minimizing the number of individuals receiving benefits.

Welfare schemes and government initiatives have, however, had mixed results. The percentage of individuals who were involved in some of the schemes and transited successfully into work was below 50 percent in the 1990s (Bambra et al., 2005); the numbers have not improved much since then (Beatty and Fothergill, 2013). Besides, while schemes such as Pathways-to-Work have been found to increase the out-flow from disability benefits, the majority of the out-flows are likely to be for destinations other than work (Lindsay and Houston, 2011). Those that do move into work are offered low-paying jobs, have unsupportive work environments, and have little or no career advancement. Hence, the majority of the governmental schemes and initiatives in the UK seem not to have delivered as expected. According to Harrington (2010), the schemes have probably had less success due to the over-reliance on systematic medical assessments, and the faulty assumption that an increase in labour supply is directly related to an increase in demand. This is more so given that even where individuals with ‘impairment’ indicate the willingness to work, impairment often acts as a major discriminator and determinant of employment prospects (Lindsay and Houston, 2011). The issue, then, is perhaps more employment-oriented than impairment-oriented. The point being that the ‘increased costs’ for both organizations and the nation may have more to do with the disadvantaged position of individuals with impairment, both in the workplace and labour market, and the absence of job opportunities, than it has to do with ‘impairment’. This study adopts the perspective that the disadvantages experienced by disabled individuals are largely a function of the structure of work. That is, BPD individuals should function optimally in the labour market, and there will be little or no ‘costs’ incurred, if work were structured to accommodate ‘impairment’ or any form of ‘difference’. This perspective of the experiences of BPD in the labour market differs from the stance often adopted in disability research, as noted in the next section.

1.5 Debates on researching Mental Health

It is widely acknowledged that disabled individuals face several disadvantages in the labour market. As discussed in Chapter two of the thesis, unemployment is one of the major barriers facing disabled individuals. Indeed, research suggests that ‘impairment’ has a more adverse effect on the experiences of work than other variables affiliated with marginalization, such as race or gender (Berthoud, 2008; Zanoni, 2011). Chapter two presents a wealth of evidence pointing to these considerable gaps between the employment experiences of BPD/disabled employees and non-disabled employees. The chapter underscores that these experiences may result due to the design of work around the notion of an ‘ideal’ employee.

Debates on the reasons for such experiences in Disability Studies have, however, evolved overtime, and researching the subject continues to be a somewhat debatable area of analysis. Previous studies have examined the reasons for the disadvantages faced by disabled employees in the labour market from either of two perspectives (Chan et al., 2010). First, there are medically inclined studies that underline the possible shortage of disabled individuals who are ready to offer their labour to employers, due to the perceived impact of impairment on the ability to work (Smith and Twomey, 2002). Secondly, there are studies that lay emphasis on the disabling obstacles and obstructive environments which prevent disabled individuals from working and earning as sufficiently as their non-disabled counterparts (Goodley, 2011). The first approach is situated within the medical sciences, and has largely governed the field of disability research (Nathwani et al., 2015). Previous considerations of impairments such as BPD tend to equate ‘impairment’ with pathology (Vickerstaff et al., 2012). Emphasis for such studies is on the adverse effects of BPD on workability, the impact of BPD episodes on functionality, educational qualifications, or even demographic features amongst individuals with BPD (Smith and Twomey, 2002), and how these facets contribute to the lower economic activity and employment rates amongst individuals with the condition (Rosa et al., 2010; Shippee et al., 2011). Michalak et al. (2007), for instance, investigated the association between workability and BPD. The research underscores the impact of BPD episodes on functionality, particularly in the workplace. Bertilsson et al. (2013) explored the degree of workability in individuals with depression, and

emphasized the adverse effects of MHCs on work capability and workplace experiences. Both studies, as with several others, seem to individualize MHCs.

Such conceptualizations have, however, been heavily critiqued from diverse standpoints. The resistance of the medical sciences particularly began with the introduction of the social model, a model that takes disability to occur within the context of social oppression (Shakespeare and Watson, 1997). In the bid to shift attention from the medicalized perspectives of ‘impairment’, the social model emphasized the structural restrictions that result in disability, and how these can be eradicated. Social modellers argue that an individualized interpretation of the experiences of impairment aids in developing tactics which target and inadvertently accentuate the functional ‘inadequacies’ of disabled individuals at the expense of significant societal and organizational features, such as the social organization of work, the work environment, and organizational practices; features which could influence the entry and sustenance of BPD individuals in the workplace (Barnes, 2012a). This is more so considering the extensive evidence of the general willingness of disabled individuals to work and retain employment (Wheat et al., 2010; Grover and Piggott, 2013). The social model went on to have a huge impact in creating awareness and propagating equality (Tregaskis, 2002), although it did receive heavy criticism (further discussed in Chapter three) for what appears to be a total disregard for ‘impairment effects’.

The impact of the model was also largely restricted to Disability Studies, and for several years after its introduction, the model’s impact within academic discourse did not translate into areas of Organization Studies, or other subject areas in sociology and the social sciences (Shakespeare and Watson, 1997). This trend has changed overtime, with scholars in Organization Studies and Business and Management, increasingly in recent times, attempting to merge the literature in Disability Studies with sociology/psychology, in order to inform and influence debates in organization literature. As a result, recent studies on ‘disability and work’ have turned attention from individualized perspectives to socialized investigations of the experiences of ‘impairment’ (Corlett and Williams, 2011; Williams and Mavin, 2015). Disability Studies has, itself, broadened to incorporate the analysis of intersecting social identities

such as gender and race (Tregaskis, 2002); while other techniques for theorizing disability have also developed as an extension of the social model, with diverse perspectives adopted over the years for exploring the disadvantages experienced by disabled individuals in the UK. Indeed, from the 1990s onwards, disability scholars have sought to move from the social model onto more refined theoretical methods for theorizing disability.

These range from studies in feminism to post-humanism, post-structuralism, critical realism and Marxist materialism. Abberley (1987), for instance, from a materialist perspective, proposes a merger between psychology and Disability Studies via the re-modification of the social model to comprise impairment. He differentiates between a social identity that does not cause ‘restrictions’ for the body, such as ‘race’ and those that cause restrictions such as impairment, noting that with gender and race, the body simply serves as a qualificatory form for the experience of social disadvantages, but with disability, the corporeal difference, while partly a result of social processes, can, itself, restrict the individual. In essence, he argues that the materiality of the body be acknowledged and integrated in research with the social modelist perspective. Post-structuralists, such as Shakespeare (1994), on the other hand, argue that the pure materialist nature of the social model devalues pertinent influential factors such as language and culture in disability analysis. They posit that social identities such as race, gender and disability are the products of social processes and discourses. There are also critical realists who argue that impairments exist independent of the constructor. That is, BPD remains factual, even though it may get entangled in social constructionist notions (Goodley, 2014). For such academics, in the absence of discourse, there continues to exist a pre-discourse realism of the body and mind. This stance naturally leans in the positivist perspective of an objective truth, which deviates from the approach adopted in the current study.

There has been a long-standing debate between these different schools of thoughts within the field of Disability Studies (discussed in Chapter three), around the better approach for theorizing the experiences of ‘disability’: researching ‘social restrictions’ (in the social model) versus ‘impairment’ (in the medical model). Indeed, regardless of

the theoretical stance adopted, research on disability continues to centre on either pathologizing disability in medical sociology, individualizing it in psychology, or emphasizing the eradication of social restrictions as implied in the social model (Shakespeare and Watson, 2001). According to Thomas (2004c), the debate on the medical versus social models is probably part of the reason alternative means for understanding disability, such as the social relational model, have remained less researched. This study suggests that perhaps the time has come to shift focus from the debate onto theorizing the adverse perceptions which exist in the workplace/society, and how these inform and maintain ableism both within and outwith the workplace. Perhaps some of the questions that remain unanswered by both the medical and social models, with regards to the experiences of social exclusion, may be addressed by underscoring the ableist social interactions that aid in maintaining such exclusion. The study, thus, extends the social model to attain a social relational understanding of the socially constructed nature of disability. Disability is taken, from the social relational modelist perspective, to be a product of the interactions between individuals who have been socially constructed as different from the norm, and individuals who meet the socialized criteria of normalcy. As noted in the theoretical chapter (three), the challenge, then, is to comprehend how interactions are established/sustained, and the particular means through which social reactions are shaped. The study adopts a Foucauldian post-structuralist perspective for theorizing the social relational model. This perspective allows for the exploration of the emergence of ‘disability’ within social interactions which are shaped by discourse, taking into consideration Foucauldian power influences (Fawcett, 1999). It opens up room to explore the role played by discourse in standardizing and maintaining notions of disability as ‘difference’ (Jammaers et al., 2016), and how these notions are further enacted within social interactions. This way, the study is seen to move from the somewhat ‘overworked’ social model analysis to a post-structuralist deconstruction of the social processes through which ‘disability’ is produced, as suggested by disability academics such as Shakespeare and Watson (2001).

Relating the Foucauldian post-structuralist perspective to the workplace, the theoretical chapter of the study delineates its theoretical aim as being to explore the specific

discursive contexts that occur within participants' workplace. The study acknowledges that the discursive context of work is moulded by individuals who replicate and draw on ableist discourse (Amsterdam et al., 2015). These are discursive contexts that have shaped and are shaped by the delineations of disability as 'deviation' from the norm. As Corlett and Williams (2011) put it, discursive practices have, over time, become permeated with ableist and medical connotations of disability as 'deviance' from the norms of 'non-disability'. The connotations are reproduced by discourse and considered 'facts' within specific contexts, which then go on to regulate people's behaviours via the means of everyday practices. The emphasis in this study is on deconstructing such discursive contexts within which participants are constructed as 'different', and depicting the role played by discourse in moulding participants' experiences and subjectivities. It is vital to note here that the specific 'context' emphasized in the study, when referring to the workplace, is in terms of the discourse and discursive contexts of work. Emphasis is on identifying the degree to which these contexts are permeated with ableist notions, and how these impact on social interactions/responses.

This theoretical stance informs the methodology and analysis chapters of the thesis. The methodology chapter is shaped around the ontology and epistemology adopted. The notion of 'objectivity' is naturally abandoned for 'subjectivity', given that the study adopts a post-structuralist perspective. Emphasis is on the 'relative' nature of the notion of disability (in relation to discursive contexts), the changeability of such notions over different discursive contexts, and the subjective judgements involved in the construction of the notion itself. The perspective adopted allows for the adoption of an analytical framework that accepts that experiences and narratives are subjective, and are influenced by discursive work contexts. The research is, thus, qualitative in nature. Semi-structured interviews were carried out with BPD employees. The discussion in Chapter four delineates how the selected approaches and techniques offer the best opportunity for attaining the research objectives. The chapter also discusses issues related to ethics and the positioning of the researcher. The findings chapters are shaped around the stance that while narrating their experiences of work, participants will take up specific positions made available by the discursive context within which they are situated. Emphasis was on understanding how such positions, either of acceptance or

resistance, come to be assumed; data was, thus, analyzed inductively using narrative and Foucauldian analysis. Foucault's analysis was specifically useful for investigating how subjectivities may develop within discursive contexts that delineate disability as 'difference'.

The first findings chapter considers how ableism is produced and sustained within normative discursive contexts and social relations. The second chapter underscores how organizational response and participants' narratives may be shaped by wider discursive practices and Foucauldian power influences, with resultant effects on participants' subjectivities. Both chapters generally contribute to Foucauldian research on the construction of subjectivities within ableist discursive practices, and develop further understanding of how power may operate in the workplace via discourse, which impinges on employees' constructions of the 'self'. The discussion chapter merges the findings in the two data analysis chapters, and relates them to existing literature. The chapter underscores how Foucauldian notions of subjectivity and power may aid in developing an understanding of the production and sustenance of internalized ableism within the workplace. The concluding chapter, then, examines the contributions and implications of the research findings, and evaluates the limitations of the study.

1.6 Significance of the study

The qualitative studies carried out on BPD have been few and far between (Nathwani et al., 2015). The majority of the research on the condition have focused on quantitative issues related to employment rates (Dickerson et al., 2004; Marwaha et al., 2013), the development of mental health policies and directives for supported work (Bevan et al., 2013), the organizational costs attached to BPD (Laxman et al., 2008), while even qualitative studies have focused on the medicalized facets of the condition. This is evidenced in studies such as Clatworthy et al. (2007) who adopt a medicalized perspective for exploring how people experience diagnosis, and the medicalization of experiences after diagnosis. The study discusses resistance to medicalization due to the fear of possible side-effects of medication, and adopts a qualitative approach. Similarly, Michalak et al. (2006) studied the effects of a BPD diagnosis on life quality, wherein BPD was found to have adverse effects on the quality of life for several participants due

to the impact of the condition on issues such as finances and work. Using a mixed methods approach, Gutiérrez-Rojas et al. (2011) explored the relationship between the particularities of BPD, such as symptoms of the condition, and social/work experiences. The findings of the study relate disablism to BPD symptoms and recurrent hospitalization. Sajatovic et al. (2008) subjectively explored the experiences of ‘disability’ among BPD individuals, in order to determine the degree to which such experiences may influence and be influenced by people as they grow older. Again, the study points to the adverse effects of BPD on people’s life plans. Several other studies have pointed to the possible conflation between BPD, work and disability, but often from a medicalized perspective (Borg et al., 2011; Bertilsson et al., 2013; Marwaha et al., 2013).

These studies, amongst others, while qualitative, seem inherently medicalized, given the focus on the impact of BPD on the quality of life and work. The emphasis on the medicalized interpretations of BPD, in addition to the often positivistic approach adopted in BPD literature, has resulted in a gap in literature on the possible constructionist interpretations of BPD employees’ narratives of work. There is a rarity of qualitative research on the means through which BPD employees may, for instance, be ‘othered’ within the context of work. Indeed, the condition remains less conceptualized as a social construction within the context of social relational and work-related literature. As Williams and Mavin (2012) put it, the vital role played by ableist work contexts in the lived experiences of ‘impairment’ remains largely under-researched. Less research connotes less visibility for the subjective experiences of BPD individuals in disability literature. This extant gap strengthens the significance of research exploring workplace experiences of BPD individuals. It is more so pertinent considering the intricacies and complicatedness which may occur within work contexts due to the invisibility of BPD. The current study offers room to comprehensively examine the lived experiences of BPD employees, underscoring how ‘disability’ may occur within ableist discursive work contexts. The study adopts a post-structuralist perspective, and repositions BPD within socialized interpretations, the aim being to contribute to an understanding of how BPD has come to be regarded as ‘difference’ within normative organizational contexts. This is done by centring on two fundamental

areas, the ableist discursive structure of work, and the impact of such structures on BPD employees' subjectivities, which is reinforced within social interactions that are shaped by ableist discourse. These two facets contribute to the subjective interpretations of BPD in the workplace, and when merged, highlight the affiliation/interrelatedness between the self and the normative discursive context of work.

It is of course important to note that the primary focus of the research is 'disability'. The study, however, acknowledges that in the process of analyzing the constructions of BPD as disability, other marginalized positions in the workplace may be found to intersect with disability. Bottorff et al. (2011) underscored the possibility of such developments in their study, noting that gender relations may often at times emerge within the theoretical context of a study. Having adopted an inductive approach, gender did emerge in this study's analysis. References are, therefore, made to gender relations in the theoretical context of the study. The study also draws on the social relational model of disability, a relatively under used model in the field of disability studies. Where the model has been adopted, it has been in relation to physical impairments rather than MHCs (Reindal, 2008; Martin, 2013; Simpson et al., 2013). The model is particularly suitable for the study, as it allows for intersections with other marginalized positions in the workplace, particularly gender. The particular research objectives and aims of the study are outlined in the next section.

1.7 Research aims and objectives

As aforementioned, there has been less research on the experiences of employees with MHCs, particularly BPD. This study addresses this gap, and aims to provide further understanding of the experiences of employees with BPD in the workplace. The study provides an in-depth exploration of employment experiences from the perspective of people living and working with BPD, with the objective of examining what factors facilitate or obstruct their employment, and how these are managed. Based on this objective, the study aims to contribute to understanding how the construct of work affects the lived experiences of BPD employees.

Specifically, the research objectives include:

1. Providing a longitudinal examination of the full range of BPD employees' experiences of work, including securing and maintaining employment, as well as returning to work after sick leave/career interruption.
2. Determining the degree to which the nature of work may be considered ableist/normative.
3. Exploring the extent to which ableist physical/social aspects of employment affect BPD employees' experiences of work.
4. Investigating the extent to which discursive practices in the workplace shape BPD employees' interpretations and experiences of work.
5. Relating BPD employees' experiences of work to developing the social relational model of disability.

Generally, the study aims to contribute to understanding and/or knowledge of BPD, by providing an in-depth assessment of BPD employees' subjective experiences in the workplace, within the context of how work is structured.

1.8 Research questions

In order to achieve the set objectives, the study addresses the following questions:

1. How do BPD employees experience securing and/or maintaining employment?
2. How do BPD employees experience work in settings intended for non-disabled employees?
3. What does the experience of BPD in the workplace indicate about the normative structure of work?
4. How are BPD individuals' interpretations and experiences of work influenced by discursive practices in the workplace?
5. How do BPD employees make sense of their position in the workplace?
6. How can BPD employees' narratives contribute to an understanding of the social relational model?

1.9 Research structure

The thesis begins with a discussion of the key themes in MHC literature, and the implications of MHCs on employment prospects. Subsequently, the thesis considers previous literature on the experiences of BPD in the workplace, and outlines the

research methodology adopted for exploring BPD employees' experiences of work. Data is presented, with particular emphasis on the influence of the discursive contexts of work on participants' subjectivities. Attention is also paid to the themes that emerge across participants' narratives, relating to the experience of 'difference' in the workplace. The thesis concludes with a discussion of the implications of the research findings. An overview of each chapter is provided below.

Chapter two: The second chapter reviews literature on the lived experiences of BPD and MHCs in the workplace/labour market. The chapter is structured around three major facets of work, that is, entry into the workplace', 'staying in the workplace', and 're-entering the workplace'. The overall aim is to gain an understanding of previous literature on BPD employees' experiences in the labour market and workplace. The chapter underscores the normative nature of work, and points to the disadvantages employees with MHCs/BPD may experience in the workplace due to such work contexts. More importantly, the research objectives are re-emphasized in light of the literature reviewed.

Chapter three: The third chapter situates the study within the context of theoretical attempts for understanding the impact of discursive definitions of difference on BPD employee's experiences of work. The chapter examines possible reasons for the misrepresentation of BPD individuals in the labour market and workplace, as evidenced by the discussion in Chapter two. The overarching aim is to offer some theoretical background for understanding the experiences of BPD employees in the workplace. Emphasis is on the influence of ableist notions on the experiences of BPD. The possible inter-relatedness between disability and gender is also discussed.

Chapter four: The fourth chapter discusses the methodological approach adopted in the study, specifically aimed at achieving the research aims and objectives. Emphasis is on the research methodology, methods, participant recruitment techniques, data collection and analytical procedures adopted in the study. Given that the aim of the study is to explore the social constructions of BPD employees, the chapter outlines the role of participants as creators of the knowledge which will result in theoretical insights.

Chapters five and six: These chapters present the findings of the study. A thematic narrative approach is adopted in Chapter five, and emphasis is on investigating the nature of work in contemporary organizations. Data is presented such as to highlight the

intricacies of work organizations, and the relatedness between employees' experiences of the workplace. Chapter six adopts a structured narrative approach, alongside Foucauldian analysis for exploring power influences, and considering the emergence of subjectivities. The chapter relates the normative context of work, evidenced in Chapter five, to participants' subjectivities. Emphasis is on the discursive influences in particular participants' narratives, and the experiences of work are placed within wider discursive frameworks.

Chapter seven: The discussion chapter merges the findings in the two previous chapters. Emphasis is on the relatedness and dissimilarities between the findings of the study and existing literature, the aim being to fully address the study's research questions, and gain some understanding of participants' experiences of the workplace.

Chapter eight: The eighth chapter concludes the study, and offers a summary of the key findings of the research. The chapter serves as a consolidation of previous chapters, merging the themes discussed, and outlining possible limitations. The implications of the research for different organizational bodies are explored.

1.10 Conclusion

This chapter delineates the study in relation to existing literature on disability and BPD. As noted earlier, MHCs are less researched in disability studies, BPD even more so than CMHCs. Where studies have focused on BPD, the emphasis is often on the individualized perspective of the condition, and the adverse effects on the self. Such emphasis minimizes the vital role played by ableist work contexts in the lived experiences of BPD. This study adopts a different perspective, positioning disability as a social construct, discursively produced within social relations, and the product of the perceptions of 'difference' in the workplace (Williams and Mavin, 2012). In contrast to previous literature, the disadvantages employees with BPD experience in the workplace are taken to largely be a function of the structure of the workplace and labour market. Having set the context of the study in the current chapter, the next chapter examines the experiences of BPD, both in the labour market and workplace, the aim being to build on the current discussion, and examine, in more detail, the exclusion BPD individuals experience.

CHAPTER 2 Bipolar Disorder in the workplace and labour markets

2.1 Introduction

This chapter offers a review of available literature on the lived experiences of BPD in the labour market. As aforementioned, due to the rarity of specific research on ‘BPD and work’, the discussion is often widened to include MHCs and disability in general. Discussion in the chapter centres on three key facets of work namely, ‘entry into the workplace’, ‘staying in the workplace’, and ‘re-entering the workplace’. The overall aim is to gain an understanding of previous literature on BPD employees’ experiences in the labour market, and provide a context for discussion in the subsequent chapter on the various means for conceptualizing disability. For this reason, the chapter considers, first, trends in the labour market participation of individuals with BPD and MHCs, examining the degree to which they are able to gain entry into the workplace. The chapter then examines possible reasons for BPD individual’s lower participation rates in the labour market, as inherent in the lived experiences of BPD employees in the workplace. Specific organizational and employment practices are considered, including recruitment and selection practices, disclosure, and experiences of work accommodations. The final section of the chapter considers the experiences of re-entering the workplace after sick leave. The chapter concludes by re-emphasizing the aims of the study, in light of the literature reviewed.

2.2 Bipolar Disorder and the contemporary labour market

According to Thornton and Lunt (1995), two facets describe the experiences of disability in the labour market. The first is depicted by the lower participation rates amongst disabled individuals, while the second relates to the disadvantages they face regarding job types/levels. The two facets are considered in this section. Specifically, the section examines the labour market trends of BPD individuals, in terms of ‘employment rates’, ‘earnings’ and the ‘types of jobs’ performed in the labour market. Using estimates from labour market surveys, the section compares the experiences of BPD individuals with that of disabled individuals, and the non-disabled populace, the aim being to highlight how BPD differs from other MHCs and impairments, with

regards to labour market participation. Subsequent sections address the possible reasons for the trends in the employment rates noted in this section.

2.2.1 Employment rates

Unemployment has been identified as one of the major barriers facing BPD individuals (Marwaha, et al., 2013). Individuals with the condition experience substantial disadvantages in the labour market when compared with non-disabled individuals and the general populace (Ridley et al., 2005; Riddell et al., 2010; Organization for Economic Co-operation and Development, 2010; World Health Organization, 2011; Longhi et al., 2012; Crowther and Sayce, 2013). This may be unsurprising given that studies have often suggested that impairment has a more adverse effect on the experiences of work than other variables affiliated with marginalization, such as race, class or gender (Berthoud, 2008; Zanoni, 2011). The figures in Table 2.1, for instance, depict that the gap in employment rates between disabled people and the general population between 2009 and 2013 has remained fairly steady over five years. As at 2016, it is 33.1 percent (ONS, 2016).

Year	Employment rate of disabled people	Employment rate of overall population
2009	39.5	71.7
2010	38.7	70.6
2011	39.5	70.3
2012	40.8	71.2
2013	39.9	72

Table 2.1: Employment rates of disabled individuals aged 16-59/64 compared to the overall population in the UK (Adapted from Office for National Statistics, 2009-2016)

The experiences of work also differ significantly amongst individuals with dissimilar impairments. The results in Coleman et al.'s (2013) study, shown in Table 2.2 below, illustrate the difference in the employment rates between some major groups of impairment and MHCs. Individuals with MHCs are found to face greater difficulty in gaining entry into the labour market, evidenced in the lower employment rates shown in Table 2.2 (Jolly, 2000; World Health Organization, 2011). According to Perkins et al.

(2009), these individuals experience comparatively high levels of exclusion, both within social and workplace contexts.

Conditions	Employed %
Diabetes	70
Chest, breathing problems	69
Heart conditions, Blood pressure, circulation	69
Stomach conditions affecting liver, kidney, digestion	69
Difficulty in hearing	64
Difficulty in seeing	59
Epilepsy	52
Progressive illness	45
Depression	42
Learning difficulties	35
MHCs, phobia, panics	21
All	61

Table 2.2: Economic status of people aged 16-59/64 in Great Britain by main health condition (Adapted from Coleman et al., 2013)

The experiences of work vary amongst the different types of MHCs. The Organization for Economic Co-operation and Development (OECD, 2014) report notes that as of 2007, of the working age individuals with severe MHCs in the UK, only 40 percent were in work; 64 percent of those with CMHCs had jobs. Both figures were lower than that for non-disabled individuals (76 percent). It is, therefore, unsurprising that several studies disclose poor employment rates for people with BPD. Of the participants with BPD in Dickerson et al.'s (2004) study, 49 percent had jobs, while in Marwaha et al.'s (2013) study, between 40 to 60 percent were in work. Individuals with BPD have been

found to have even lower employment rates than individuals with unipolar depression (Lazowski et al., 2012). While the majority of the studies that point to these disadvantages were carried out using a quantitative approach, they do indicate that individuals with BPD and MHCs experience some challenges in gaining entry into the world of work. Another major representation of the disadvantages BPD individuals experience in the labour market relates to the types of work obtainable in the labour market. This is examined in the next sub-section.

2.2.2 Horizontal and vertical labour market segregation

Disabled individuals are often unevenly distributed among certain occupations, compared to non-disabled contemporaries (Barnes and Mercer, 2005a). Such individuals may be under-employed, or found in jobs for which they are overqualified (Jolly, 2000). Table 2.3 depicts the under-representation of disabled individuals in professional, supervisory, and managerial professions compared to non-disabled peers (England, 2003; Barnes and Mercer, 2005a).

Occupation	Non-disabled %	Disabled %
Higher managerial and professional	15	9
Lower managerial and professional	28	25
Intermediate occupations	14	14
Small employers and own account workers	9	10
Lower supervisory and technical	8	9
Semi-routine occupations	14	18
Routine occupations	11	13

Table 2.3: Occupation of people aged 16-59/64 in employment, Great Britain by disability (Adapted from Coleman et al., 2013)

Several studies confirm the representative figures in Table 2.3. Coleman et al.'s (2013) study reveals that 33 percent of disabled individuals are in part-time jobs, while it was 25 percent for non-disabled employees. Individuals with MHCs have also been found to

have a higher probability of being in part-time work, compared to individuals with physical impairments. Twenty-three percent of individuals with MHCs or learning difficulties in Coleman et al.'s study were in non-standard jobs, compared to 21 percent of individuals with other forms of impairment. Of the 117 participants who had BPD and were employed in Dickerson et al.'s (2004) study, several worked on a part-time basis. Only 27 percent of the employed individuals had standard work arrangements, 21 percent had non-standard jobs. The remaining participants were not in work. Even in instances where individuals with BPD have higher qualifications, as evidenced in Gilbert and Marwaha (2013), such individuals have been found to be in lower level jobs compared to their contemporaries. Non-standard jobs tend to be precarious (Schur et al., 2006; Shuey and Jovic, 2013); hence, BPD employees in such jobs may have fewer career prospects and opportunities (Kitchin et al., 1998; Jolly, 2000; Hall and Wilton, 2011), and lower earnings than contemporaries. Disabled employees' earning rates are further examined in the next sub-section.

2.2.3 Earnings

Disabled individuals, particularly individuals with MHCs, earn lower than colleagues, even in the absence of differences in productivity (Roulstone and Barnes, 2005; Longhi et al., 2010). According to Gottlieb et al. (2010), disability is often related to reduced earnings, compensation, training, and employee involvement. The average earning for non-disabled individuals per hour in 2012, for instance, was £13.25, while it was £12.15 for disabled peers (Crowther and Sayce, 2013). As illustrated in Table 2.4, 30 percent of disabled employees earn below the living wage.

	Non-disabled %	Disabled %
National minimum wage or below	14	15
More than national minimum wage but below living wage	12	15
All below living wage	26	30
Living wage or above, up to £10	19	21
More than £10, up to £20	39	37
More than £20	16	12
All more than £10	55	49

Table 2.4: Earnings, people aged 16-59/64 in employment, Great Britain
(Adapted from Coleman et al., 2013)

These differentiations do differ from one workplace to the other, and may be reduced where there are high levels of acceptance and acknowledgment of difference (Gottlieb et al., 2010). They are, nevertheless, more evident in professional jobs or managerial roles, and occur less in ‘office’ job positions, social care, nursing jobs, and so on (Crowther and Sayce, 2013). Longhi et al. (2010) posit that the difference in earnings is partly due to the disproportionate representation of disabled individuals in non-standard forms of work. This is more so given that such work is typically characterized by lower earnings as a result of shorter contract periods and reduced working hours (Broughton et al., 2010). Essentially, this suggests that BPD individuals may be prone to earning less than counterparts (Schur et al., 2006; Coleman et al., 2013). It is, of course, vital to note that such differentiations also occur due to other social identities. Travis (2015), for instance, posits that in spite of the improvements that have occurred with regards to gendered differentials over the years, progress seems to have decreased in recent times. In 2012, the average pay for female employees working full-time was 76.5 percent of the average pay for men - similar to what was recorded in 2001 (Travis, 2015). The pay differentials are more evident where intersections occur with race, and are evident even after taking features such as working hours, skills, and educational background into consideration.

The figures presented in this section depict the disadvantages BPD individuals may experience in the labour market. As above-mentioned, several studies suggest that the disadvantages result from the decreased workability of BPD individuals, and the inability or unwillingness to work. This study argues otherwise, and places BPD individuals' experiences within the context of work. The rest of the chapter investigates the degree to which the nature of work may create expectations which are difficult for BPD employees to achieve, resulting in a disadvantaged position for such individuals.

2.3 Lived experiences of employees with Bipolar Disorder

Beyond the focus on the evident measures of exclusion, as demonstrated in the labour market characteristics of BPD individuals in the previous section, this section offers an in-depth examination of understated forms of bias. The disadvantages faced by BPD employees are increasingly a function of unaccommodative workplace processes (Sturm, 2001). This section lays emphasis on such organizational processes, examining them within the context of the lived experiences of BPD employees. It is vital to note that the current study identifies with the socialized perspective discussed in this section, in contrast to the medicalized and individualized perspective of disability. The section considers pertinent employment practices such as recruitment and selection, the organization of work, and the provision of workplace accommodations. The aim is to further illustrate how BPD employees may be disabled or excluded in the workplace due to the nature of work and the work environment. Again, given the rarity of research on BPD in the workplace, the discussion is widened to include the somewhat bigger body of work on MHCs and disability in general.

2.3.1 Recruitment and Selection

The Equality Act 2010 prohibits discrimination during recruitment and selection processes on the basis of sexual orientation, age, race, gender, and disability. Literature, nevertheless, demonstrates that 'exclusionary tactics' may often be employed during recruiting processes, which result in disadvantages for individuals constructed as 'different'. Organizations, for instance, according to Braddock and Bachelder (1994), will not naturally recruit disabled candidates for managerial and specialized roles. In

support of this, Braddock and Bachelder (1994), having reviewed job adverts for managerial and specialized positions over the period of a year, posit that disability is not specifically acknowledged in job adverts as much as gender and race are. In the study, disabled individuals were specifically acknowledged for managerial positions in only 27 percent of adverts, while gender and race were acknowledged in about 46 percent. While the study was conducted over 20 years ago, there is evidence in recent literature that it remains the norm to have job descriptions which inherently mandate non-disability as a criteria (Shier et al., 2009; Biggs et al., 2010; Harpur, 2014), alongside masculinity, whiteness, and so on. These are requirements that may solidify patterns of exclusion for individuals who are unable to meet them.

Aside from the implied and covert exclusionary methods, studies depict that organizations may also overtly display reluctance to employ BPD candidates, particularly where BPD is declared during the recruitment and selection process. Participants in Harpur's (2014) study experienced discrimination during recruitment procedures, due to the disclosure of a series of impairments. Participants of the study noted that they had been invited to fewer selection interviews compared to their non-disabled contemporaries after graduating from school, even where they had higher qualifications. Harpur (2014) did adopt a social model perspective, and emphasis was on physical impairments. The study, nevertheless, points to how impairment may serve as a delineating factor during recruitment process, and underscores the possible reasons for the disadvantages faced by BPD candidates in the labour market. Similarly, in Schur's (2003) study, participants noted that they had not been considered for jobs as a result of their 'impairment'. In Kitchin et al. (1998), participants had experienced successful interviews, but were refused job offers on disclosing their impairment. Participants in Shier et al.'s (2009) study suggest that the best approach was to ensure potential employers were not aware of an applicant's 'impairment'. Participants had been invited for interviews, and, after requesting for wheelchair accessibility, were disqualified. One participant described how, on seeing their walker, potential employers immediately perceived them as incapable. A job applicant in Newton et al.'s (2007) study could not get a job interview done for several weeks, due to the temporary

absence of a lift. Again, while these studies explored the experiences of impairments in the labour market, little or no attention was paid to MHCs or to BPD in particular.

The studies, nevertheless, indicate that selection procedures could inherently be unobjective, or simply aimed at selecting the ‘ideal’ employee for the job. As Biggs et al. (2010) suggest, employee selection techniques need to be assessed if improvements are to be made with addressing the disproportionate representation of disabled individuals in the labour market, which continues to exist despite legislation such as the Equality Act 2010. The next sub-section considers other exclusionary facets of work, as evidenced in existing literature.

2.3.2 Organization of work

Certain undocumented, invisible, and informal organizational patterns and practices can produce restrictions for, and systematically disadvantage individuals with any form of ‘impairment’ (Harpur, 2014). The increased pace of work, expertise, expectations that employees be able to rotate jobs, application of teamwork, and varying access to resources, amongst other factors, creates ‘pressure’ in contemporary workplaces, and demands some form of employee flexibility, particularly in specialized or managerial positions (Lysaghta et al., 2012). These factors could inadvertently create structural concerns or barriers for employees who think or work at a different pace, or have different levels of energy (Wendell, 1996). As Wendell puts it, an increase in the pace of work increases the chances of individuals becoming ‘disabled’ in the workplace, as more people become defined as unable to meet the standard norms of productivity. The ‘corporeal’ differences of individuals unable to meet standard norms become visible and disabling, where they might have been unobtrusive and unrelated to performance within slower-paced contexts (Wendell, 1996). This suggests that the contemporary nature of work could, itself, be a key site for the constructions of BPD as ‘disability’ in the current society (Williams and Mavin, 2012).

Several studies have suggested that the nature of work excludes employees with ‘impairment’. Zanoni (2011) examines how diversity may be re-conceptualized, using a company known for its positive stance on diversity as a case study. The author adopts a

range of qualitative methods for obtaining the stories of employees and HR managers in an automobile factory. The results point to how jobs may be standardized with routine tasks, encouraging employees to develop set sequences, and perform tasks speedily, with resultant effects on disabled employees. The disabled participants of the study were considered by colleagues and superiors as unable to cope with the pace of work, and in some cases, as using avoidance tactics in order to evade work. Disability, thus, carried a negative connotation of inability in the case study organization. While the study does not lay particular emphasis on employees with BPD, the findings buttress the argument in the current chapter on the disabling nature of work. De Luca (2014) similarly examined the everyday experiences of BPD individuals. Interviews were conducted with six participants, and data was analysed using thematic analysis. Respondents of the study note how changes in the nature of work, and the introduction of highly-placed individual targets triggered a decline in their MHC, making work more challenging. The methodological approach adopted in the study does have some degree of limitation, given the analysis was not placed within a conceptual context. De Luca's study, nevertheless, underscores that the nature of work plays a central role in BPD employees' experiences of work.

Another study that points to this was conducted by Foster and Wass (2012). Foster and Wass explored the possible reasons for the continued disadvantages faced by disabled individuals in employment. The study employs secondary data from Employment Tribunals (ETs), the aim being to underscore how the exclusion disabled individuals experience in the workplace may be the result of fixed job descriptions and normative organizational contexts. Some of the claimants in the study had been offered job roles that were evidently difficult to achieve without adequate provisions. A claimant with a knee injury, for instance, was offered the role of customer service officer, which involved assisting clients 'to and from the departure gates' (Foster and Wass 2012, p.713). Accommodations were not provided, and as a result, the claimant was eventually dismissed from work on the basis of 'inability'. Another claimant was unable to perform some roles within a set of standard roles in a production system, resulting in difficulties for the employee. The claimant's 'inability' was highlighted due to the inflexible nature of work in the organization. The majority of the claimants in Foster

and Wass found work challenging due to such narrow approaches to work, and the unwillingness of their workplaces to 'reorganize' work. Jones (2005) examined the experiences of BPD individuals within unaccommodative work contexts. The author carried out eleven interviews with BPD individuals, and analysed data using the grounded theory approach. The research findings highlight the interrelatedness between the demands of work and workability. Work was found to instigate a recurrent form of declining health and functionality amongst participants with BPD. The study, as with the aforementioned studies, points to how the pace and structure of work may contribute to the disablement/exclusion of individuals with any form of impairment.

Aside from the pace or structure of work, physical restrictions in the workplace can also prove disabling (Wendell, 1996). Restrictions could range from constricted doorways and top-layer shelves for individuals with physical 'impairments', to issues with noise or acoustics for BPD individuals (Braddock and Bachelder, 1994). For one participant with Asperger's Syndrome in Lindqvist and Lundälv's (2012) study, work was challenging due to the amount of noise and murmuring that occurred in the workplace. The participant experienced depression as a result, and was ultimately dismissed from work. Another participant with hearing impairment in Newton et al.'s (2007) study described the experience of arriving for a job interview and being stranded outside the building due to the inaccessibility of the intercom. The participant was unable to gain access into the building until the next job applicant turned up. One participant had lost job opportunities due to the lack of wheelchair access, while another had missed office meetings due to the location of meetings in buildings with heavy un-automated doors. Missed meetings and lower participation rates in the workplace often result in missed career opportunities for employees with 'impairments', further strengthening ableist views of such individuals as unable to work. Again, the majority of the studies mentioned explored experiences of physical impairments. While some insight is gained from these studies on the experiences of impairment within the context of work, the disablist nature of work for individuals with BPD remains less researched.

The inaccessibility of work indicates possible restrictions in the number of potential jobs BPD individuals can apply for, and successfully perform. In addition, the social

perceptions of inability point to reduced career prospects. Participants in Von Schrader et al.'s (2013) study, for instance, described instances where they had lost career opportunities due to contemporaries' and superiors' assumptions of their incapability. In Michalak et al. (2007), several BPD participants observed that their employers perceived them as having below average potential for progression or promotion. A major means for reducing these effects, and improving accessibility/enabling BPD employees in the workplace is through the availability of workplace accommodations. Work accommodations determine, to a large extent, the experiences of BPD individuals in the workplace (Baldrige and Swift, 2013). Evidence suggests that accommodations are vital if BPD individuals are to succeed at work (Tremblay, 2008). The next subsection explores the degree to which accommodations have successfully enhanced the experiences of BPD and MHCs in the workplace.

2.3.3 Workplace accommodations

Having established the disablist nature of work in the previous section, the current section turns attention to what is currently known on BPD employees' experiences of work accommodations. It is vital to note that BPD may have diverse connotations for employees with the condition, and generate different accommodation needs in the workplace. Organizations are, nevertheless, mandated by the Equality Act 2010 to provide accommodations for both prospective and current workers, where this is considered necessary (Dickens, 2007). The significance of this facet of the Equality Act is that it challenges the match between job roles and employees' capabilities (Foster and Wass, 2012). The provision of accommodations highlights the need for organizations to do more than attempt to fit disabled individuals into positions intended for non-disabled individuals (Williams-Whitt and Taras, 2010). The policy may, of course, also be interpreted as placing BPD individuals in the position where they have to adapt and conform to organizational norms, albeit via applicable legislation (Fevre et al., 2013). As Tatli (2010) puts it, such policies do not question the 'status quo' systems for organizing work. Evidence, nevertheless, suggests that accommodations aid in eliminating the features of work that generate barriers, enabling BPD employees to have better opportunities to compete on equal terms with colleagues (Balser, 2007).

Accommodations do constitute a variation to the standard approach to work (Foster and Wass, 2012), and could be perceived as disruptive to organizational processes. By necessitating workplace adjustments, BPD employees may place demands on everyone's perception of work, which could be unwelcomed by colleagues and employers (Cockburn, 1991). This is demonstrated, for instance, in Bertilsson et al.'s (2013) study. Bertilsson et al. investigated the workability amongst individuals with depression and anxiety, carrying out four focus groups with seventeen respondents in work. The data collected was analysed using a phenomenological approach. The data points to how participants' need for intermittent breaks was perceived by colleagues as disruptive, and as some form of liability, thus underlining how work accommodations may be perceived as deviations from the standard approach to work.

Studies also point to the reluctance in contemporary organizations to accommodate 'difference'. Tremblay (2008) examined the particular features that improve workplace experiences and productivity for BPD employees. The author carried out a survey of 39 BPD individuals, and one of the findings underscores possible experiences of bias and stigma due to accommodation requests. Foster (2007) conducted an exploratory study on disabled employees' experiences of securing work accommodations. Participants in Foster's study described instances where their employer refused to acknowledge their impairment. A teacher with visual impairment received a workload which had inaccessible teaching material, with no accommodations immediately provided. For the teacher, the lack of adequate support resulted in numerous incidents of sick leave, and subsequent retirement. Another participant who was a wheelchair user was assigned office space in a room where manoeuvring was particularly challenging, and asked to 'put up her hand' if in need of the restroom (p.76). The study highlights the relationship between the mistreatment of disabled employees and the modifications they need in the workplace in order to work effectively. Participants in Tezcan's (2013) study had similar experiences. One participant with visual impairment noted that 'screen decoder software', a vital form of accommodation, had not been purchased for about five years in their company.

Foster and Fosh's (2010) study also reveals that disabled employees often face difficulties in securing the needed adjustments to their work provisions. Some of the respondents of the study cited cases where decisions were made concerning them without prior consultations, while others noted instances where the validity of their requests for accommodations was challenged. Such responses may, at times, be related to the ill-equippedness to manage employees with 'impairments' in contemporary organizations. This is evidenced in Naraine's (2005) study where, even though the case study organizations had employed individuals with visual impairments, the workplace was neither socially nor physically prepared to cater for such individuals. These studies suggest that organizations may often adopt an inflexible interpretation towards the employment of individuals with 'impairment'. As already mentioned, contemporary work may fundamentally be designed around non-disability. Hence, achieving an organizational 'fit' in the absence of accommodations may be difficult for BPD employees. These practical reasons, amongst others, point to why BPD employees may face difficulties in the workplace. The majority of the aforementioned studies do pay more attention to physical impairments than MHCs, again, highlighting the paucity of research on the lived experiences of MHCs and BPD in the workplace.

This sub-section examined vital facets of the experiences of disability and BPD in the workplace, culminating in the discussion on workplace accommodations. The section underscores the disabling effects of the ableist nature of work on individuals with 'impairment', which necessitates work accommodations for such individuals. BPD does differ from physical impairments, given that securing work accommodations is largely dependent on disclosure. There are no 'physical identifiers' for the condition. Hence, experiences of work are dependent on the degree to which an individual either embraces or repels the condition as a part of the 'self'. BPD employees, therefore, play a major role in the instigation of accommodative processes, by deciding whether to disclose the condition or not. Attention turns to disclosure in the next sub-section.

2.3.4 Disclosure

According to Farmer (2011), employees with MHCs are often faced with the dilemma of either disclosing or not. This sub-section discusses existing literature on the

experiences of disclosing BPD/MHCs in the workplace, and the role played by work contexts in disclosure decisions.

Several impairments have little or no visual indicators, and are not immediately obvious to the untrained eye. BPD belongs to this ‘category’ of invisible or hidden conditions (Irvine, 2011). There are essential differences between these conditions and visible impairments. Individuals with evident ‘impairments’ may have no choice other than to disclose. Wilton (2006) reiterates this in a study which explores the experiences of disclosure in the workplace. The study adopts a combination of quantitative and qualitative techniques, with particular emphasis on the influence of work contexts on disclosure decisions. Several participants with physical impairment had to disclose due to the evident nature of the impairment. As noted in the study, the physicality of impairment may leave job applicants and employees with little or no choice other than to disclose. Participants observed that such disclosure often reduced their career prospects. This naturally differs for individuals with invisible conditions like BPD. The comparative invisibility of BPD results in a situation where prospective employers do not have prior knowledge of a candidate’s ‘impairment’, leaving the choice to such individuals as to when and if to disclose, and to whom (Brohan et al., 2012). This is supported by employment legislation, as job applicants are not mandated in the UK to divulge an impairment before being hired (Duncan and Peterson, 2007).

The majority of employees would rather keep MHCs hidden due to the perceived advantage of being regarded as ‘normal’, and the fear of being treated unfairly during employment processes (Brohan et al., 2012). Several studies illustrate this fear of disclosure. Von Schrader et al. (2013) present the results of a quantitative study carried out with disabled people, the aim being to identify the particular determinants and influencers of disclosure decisions. In the study, participants with physical ‘impairments’ were more inclined to disclose at work than participants with invisible conditions. Where participants had both physical impairments and MHCs, several disclosed only the physical impairment. Participants of the study relate non-disclosure to the fear of missing out on job prospects, being dismissed from work, or missing promotions. Participants also noted that given the current misconceptions of disability

as incapability, the risks attached to disclosure were quite high. This is similar to the findings in the aforementioned Wilton's (2006) study, where participants with MHCs were less likely to have disclosed at work (78 percent did not disclose). The majority noted that the stigma attached to MHCs influenced their decision not to disclose. Participants also felt that the decision to disclose led to their discharge from previous jobs. In Kearns and Gesler's (1998) study, participants believed that they would lose their jobs and be denied work elsewhere if they disclosed. Similarly, Tiedtke et al. (2010), having studied the experiences of female breast cancer patients in the workplace, note that participants largely demonstrated fear of the stigma attached to the condition.

Such fears are not unwarranted, as several studies have shown that disabled people experience disadvantages in the workplace; people with MHCs more so than others. Individuals with MHCs and AIDS, according to Baldwin and Johnson (2000), experience the highest level of bias compared to other impairments, with disclosure, at times, resulting in dismissal from work (Wilton, 2006), exclusion (Hale, 2011), victimization, harassment, or reduced career prospects (Von Schrader et al., 2013). Disclosure seems to largely generate adverse reactions in the workplace. While the several empirical studies pointing to such disadvantages aid in developing an understanding of the experiences of disclosure in the workplace, and the particularity of having invisible conditions, it is vital to note that the majority stem from quantitative investigations. Where studies such as Wilton (2006) adopted qualitative techniques, this was in conjunction with the quantitative approach, with no particular conceptual framework adopted. The studies, however, offer a basis for comprehending the experiences of disclosing an impairment in the workplace.

Where an invisible condition is undisclosed in the workplace, employees often present themselves as members of the prevailing social category of non-disabled people (Wilton, 2006). This involves taking particular measures in order to keep the condition undisclosed. A participant in Wilton (2006) with Crohn's disease, for instance, avoided eating at work in order to avoid using the restroom frequently, or raise any form of curiosity. Another participant with BPD put cotton balls in their medication bottle, so

that the medication would not rattle. Participants with depression in Bertilsson et al. (2013) also went to great lengths to keep the challenges they faced at work hidden, while participants in Kearns and Gesler (1998) restructured their approach to work and curtailed social activities, in order to avoid disclosure. Several employees in Tiedtke et al. (2010) decided to leave work in order to avoid disclosing their diagnosis of cancer; others missed treatment appointments so as not to lose their jobs. Aside from these tactics, studies also point to the adoption of an alternative self at work, whereby the 'contented' self is presented to the public, rather than the 'distressed' self (McGinn, 2009), the aim being to conceal an impairment. Employees undergo what Hochschild (2003) terms emotional labour, where they attempt to keep a distance between individual feelings and the emotions displayed at work. According to Valeras (2010), such emotional regulation results in interchangeable identities, thus, highlighting how identity may be contingent and unsolidified. More importantly, such regulation may have negative effects on employees' physical and mental health (Kumar et al., 2010). The consistent overlapping of identities could result in employees alienating themselves from their personal feelings, or cause a relapse for employees, particularly in the absence of the required support and adjustments.

Another major consequence of non-disclosure is that employees cannot request for accommodations in the workplace. As noted earlier, disclosure is an integral facet of the Equality Act's provision for work accommodations. The Act proscribes indefensible unfavourable dealings with individuals with BPD, and mandates organizations to provide accommodations where needed (Brohan et al., 2012). Work accommodations will only be available, however, where the organization/employer is aware that an employee has an 'impairment' (Finch, 2007). Hence, the non-disclosure of BPD could result in employees being inadequately supported at work. Given these consequences, Lingsom (2008) recommends proper consideration of both costs and benefits when making disclosure decisions. Whichever route employees take, disclosure plays a major role in shaping the experiences of impairment in the workplace (Irvine, 2011). It is, of course, easier if employees are certain that disclosure will be kept in confidence, and where revealed, will have no negative consequences. It is, therefore, imperative that

organizations build work environments that do not allow discrimination, and a context that encourages employees to reveal their ‘impairments’.

One of the possible determinants of disclosure, as noted in literature, is the nature of work. According to Wilton (2006), the manner in which disclosure takes place, and the ‘when’ or ‘how’ of disclosure is determined, to a great degree, by work contexts. Wilton suggests that employees in non-standard jobs, with lower earnings or lower job security, may find it difficult to disclose or request for workplace adjustments. Conversely, employees working full-time, with standard working arrangements may have better opportunities for workplace accommodations. Roulstone et al. (2003) affirm this in their study. The authors, using a mixed methods approach, examined the experiences of disabled employees in the workplace across the UK. They suggest that the provision of workplace accommodations is largely dependent on the type of organization. This is indicative of the role played by the context/structure of work, in disabled individuals’ experiences of work, a significant insight for the current study, given the emphasis on contexts, both social and organizational.

This section discussed existing literature on the experiences of disclosure in the workplace. The section reveals the added complicatedness of BPD due to its invisible nature, and points to how experiences of the condition within work contexts may largely depend on disclosure. Aside from work contexts, the one facet of work that merges all the aforementioned facets of work is the nature of social relationships in the workplace. As Gates (2000) suggest, performance and functionality in the workplace are largely dependent on social relationships. Workplace support and accommodations, for instance, have to be negotiated within the context of social interactions. The role played by social interactions in the workplace is, therefore, discussed in the next section.

2.4 Social relationships

Social relationships and interactions play a major role in determining BPD employees’ experiences of work (Bertilsson et al., 2013). Where the condition is disclosed, social response is often found to have an impact on the overall experience of work, and may ultimately limit workplace experiences. Employees with the condition, for instance,

could be well aware of what accommodations they need in order to perform at work. The availability of accommodations is, however, somewhat dependent on social relations with people in the workplace (Gates, 2000; Williams, 2011). This suggests that BPD employees may be disadvantaged due to organizational response (Wheat et al., 2010; Martin, 2013). Managers, in particular, have been found to discriminate against workers with MHCs by stifling promotional prospects, micro-managing, or over-attributing errors made by employees to their MHC (Cunningham et al., 2004; Wheat et al., 2010). Such adverse organizational responses reinforce societal responses, and are indicative of how BPD employees come to be considered as deviating from the norm (Grenier, 2007). Social relationships with colleagues could also be disabling. Employees with 'impairment' have been known to experience adverse relationships with colleagues in the workplace. According to Wheat et al. (2010), co-workers often place employees with MHCs in the role of 'deviance' through indirect systems of segregation. Disabled employees in Harpur's (2014) study, for instance, note that colleagues would at times exclude them from participating in collective tasks, while the employees in Hale (2011) experienced doubt from colleagues, who would not accept that BPD was a condition in itself. The experience of exclusion may prove disabling, particularly where employees give emphasis to having social relationships, and desire to fit in at work (Malove, 2012). As Bertilsson et al. (2013) note, fitting in at work could be a vital contributor to performance and productivity. Social relations could, thus, be significant contributors to BPD employees' experiences of work, and contribute to receptiveness in the workplace.

As already mentioned, the discussion in this chapter revolves around three major themes, 'entry into the workplace', 'staying in the workplace', and 're-entering the workplace'. Having examined the first two, the next section examines the final theme, which is the process of re-joining the workforce after sick leave, or time off work.

2.5 Returning to work

This section examines BPD employees' experiences of returning to work after sick leave. Return-to-work (RTW) procedures are particularly pertinent to the study due to the episodic nature of BPD. BPD employees may, at times, need to take time off work.

They, nevertheless, re-enter the labour market at some point (Goldberg et al., 2005). As Laxman et al. (2008) put it, BPD is often linked with the propensity to take time off work, this would, however, usually be periodic. Hence, the consideration of the lived experiences of BPD at work would be incomplete without considering the experiences of returning to work after sick leave.

Studies depict that where sick leave and RTW procedures are not well managed, sickness absence may turn to 'unemployment' (Wynne et al., 2004). According to Wynne et al. (2004), the transition from longstanding sick leave to redundancy is a well-known sequence. Bipolar UK (2013) posits that only 50 percent of people on MHC-related sick leave for over six months will return to work. It decreases to 25 percent after a year, and five percent after two years. Harrow et al. (1990) surveyed individuals who had experienced a manic phase, and after nineteen months, only 42 percent were in work, while 23 percent had been out of work. Wynne et al.'s (2004) study revealed a lower return rate, depicting that 80 percent of employees on sick leave for more than six weeks will need support if they are to move back into work successfully. In essence, the more time an employee spends on sickness absence, the less likely, and more challenging it is for such an employee to transition back into work (Lelliott et al., 2008). Organizational techniques and tactics for assisting BPD employees continue and remain in employment play a major role in preventing employees from embarking on absences which ultimately result in segregation. Several organizations have adopted RTW policies in the bid to improve RTW rates (James et al., 2002). While these techniques have been effective, to some degree, in regulating the length and rate of sick leave, and aiding employees to return to work (James et al., 2002), studies continue to depict negative RTW rates in the UK (Higgins et al., 2012). Higgins et al. (2012) evaluated 269 articles on sick leave, the aim being to highlight the possible effects of relative enablers/dis-enablers on employees' experiences of sick leave. The study notes that sick leave, in the public sector alone, is projected to be about 190million working days each year (Higgins et al., 2012). It has become one of the major routes through which disabled individuals leave the labour market.

Several factors could constitute limitations to returning to work. Andersen et al. (2012) posit that limitations may result from feelings of uncertainty amongst returning employees about the ability to cope with the demands of work. Wynne et al. (2004), on the other hand, lay emphasis on the nature of work environments as major determinants in the precipitation of cycles of absence. Tse and Yeats (2002) similarly note that limitations could result from work environments, particularly with regards to the provision of work adjustments, and the response received from the organization/colleagues. RTW rates have been found to vary in direct correlation with the levels of support available in the workplace (Williams and Westmorland, 2002; Tiedtke et al., 2010). This is evidenced in Yassi et al.'s (1995) study where the RTW procedures for 250 nurses with lower back pain was appraised over a period of two years. The 250 nurses were promptly evaluated, and provided with workplace accommodations where needed. On comparing the work outcomes of the 250 nurses with that of nurses who received a different form of treatment at work, Yassi et al. (1995) discovered that there was a 34 percent reduction in the time lost at work for the 250 nurses, while there was an increased rate of sickness absence for the second group. The quantitative approach adopted in Yassi et al. (1995) does limit the subjectivity obtained from the participants of the study.

Similarly, Bouknight et al. (2006) explored the RTW experiences of breast cancer survivors. Participants of the study were more inclined to return to work where they felt that their employer would provide adjustments in the workplace. In Meager et al.'s (1998) study, over 25 percent of participants who had resigned from work would have stayed on if their employers had offered the necessary accommodations. Butler et al.'s (1995) survey revealed that employees who had been offered accommodations (such as reduced workloads, improved equipment, or flexible working hours), had a higher propensity for returning to work permanently, and not having many sickness absences in the future. The chances of RTW were found to increase by 35 percent where employees were offered workplace accommodations; while the probability of such employees having subsequent sick leave reduced by 71 percent. In Spelten et al.'s (2002) study, work-related features were one of the major factors influencing the RTW rates of employees with cancer. The need for emotional support during RTW processes

was particularly noted. Similarly, several participants in the aforementioned Tiedtke et al.'s (2010) study valued the social relationships at work, even during chemotherapy treatments, which encouraged them to return to work. In the absence of such support, there is a higher tendency for employees to leave work for prolonged periods, or have adverse experiences of work upon resumption (Wynne et al., 2004).

One of the major influences on the reception and support returning employees receive in the workplace is the nature of impairment for which employees went on sick leave (Tjulin et al., 2011a). Employees returning from absences related to MHCs tend to have a less favourable response from colleagues, compared to individuals with physical impairments, particularly where colleagues performed their tasks during their absence (Lelliott et al., 2008). Tjulin et al. (2011a) examined the degree to which colleagues' responses varied based on the reasons for taking sick leave. Thirty-three individuals were interviewed, and RTW strategies were secured from three organizations. The study reveals that individuals returning from a long-term sickness absence due to a MHC raised more apprehension in the workplace, compared to employees who had been on short absences for physical conditions. Colleagues displayed wariness and doubt with regards to the returning employees' condition, and the ability to work. Such social factors, in terms of the outlooks and reactions of colleagues, in addition to relationships within the workplace, often play a major role in RTW procedures. It could result in a situation where, rather than experience support, employees returning from sick leave feel secluded. The provision of workplace accommodations and support, therefore, forms a vital facet in RTW procedures.

This section examined the experiences of BPD employees, with regards to RTW processes in the workplace. The section illustrates that where there is a low incidence of support during RTW procedures, RTW rates could fall. The provision of work accommodations and support from supervisors/co-workers is, thus, a vital element for achieving positive RTW outcomes. This, again, highlights the importance of the work environment in shaping the experiences of BPD individuals in the workplace.

2.6 Conclusion

This chapter explored the lived experiences of BPD and MHCs in the workplace. Discussion centred around three key facets of BPD and work, 'entry into the workplace', 'staying in the workplace', and 're-entering the workplace'. The chapter presents a wealth of evidence pointing to considerable gaps between the employment experiences of BPD/disabled employees and non-disabled employees. The majority of the studies examined focus on the exclusion of employees with physical impairment or CMHCs, with particular emphasis on the analysis of employment or pay rates. There is, thus, copious knowledge of the employment indicators and experiences of employees with physical impairments, but sparse knowledge of the lived experiences of BPD/MHCs in the workplace (Schur et al., 2009). Where studies have focused on the lived experiences of BPD, the majority, as evidenced in the chapter, have adopted quantitative techniques, or addressed issues such as the impact of BPD on workability. While these studies offer some insight, and improve the general understanding of the experiences of BPD, they fail to address the reasons for such experiences, and the very assumptions on which work is constructed. Hence, less is known about the socially constructed nature of work, or how BPD has, itself, come to be identified as a form of deviation in the workplace. Essentially, the current study addresses this extant gap in literature by focusing on the experiences of BPD employees in the workplace, within the context of how work is structured. Emphasis is on the process through which ableist structures are constructed and replicated in the workplace, as inherent in the experiences of BPD employees. The study contributes to a theoretically inclined understanding of the inherent reasons for the exclusion BPD individuals experience in the workplace and labour market.

Having developed some understanding of the lived experiences of BPD employees in the workplace in this chapter, attention turns to the theoretical framework for understanding such experiences in the next chapter. As Radermacher (2006) notes, if the persistent discrimination and disadvantages experienced by BPD employees are to be addressed, it is important to understand how BPD is conceptualized in the workplace. This is addressed in the next chapter.

CHAPTER 3 Conceptualizing Bipolar Disorder and disability

3.1 Introduction

The experiences of BPD in the workplace, and the degree to which BPD employees experience exclusion of any sort are considerably dependent on how BPD is conceptualized and construed (Radermacher, 2006). Hence, if reasons are to be sought for the disadvantages experienced by BPD employees, it is pertinent to understand how BPD is conceptualized. This chapter conceptualizes disability, and examines the implications of the different conceptualizations of disability for BPD employees. The overarching aim is to offer some theoretical background on the discussion in the previous chapter, and underline the theoretical stance adopted in the current study. Particular attention is paid to the discursively constructed nature of BPD. The chapter is set out as follows: first, the two major models of disability are examined. The chapter then examines the critiques been levied on the social model, and the responses to these critiques before discussing the extended version adopted in the study namely the social relational model. Subsequently, the chapter offers a theoretical perspective on discussion in the previous chapter, by examining the social constructionist and post-structuralist perspectives of BPD. Finally, the chapter develops a Foucauldian perspective of the conception of power, and its influence on the constructions of 'difference' in the workplace, before considering the gendered stance adopted in the study and the correlation between the social relational model and the post-structuralist perspective.

3.2 Models of disability

Disability generally exists at an overlap between the specific demands of a given impairment, society's construal of the impairment, and the broader economic or political environment (Albrecht et al., 2001; Saltes, 2013). Various standpoints and philosophies have developed overtime with regards to the concept, which have impacted on the current debates on BPD. The several standpoints, according to Glouberman (2001), culminate into two major positions. First, there are disability theorists, who focus on the individual as an entity, with the disabled body considered an adverse threat

to the entirety of the 'self'. Then, there are those who underline contexts (social or physical) and consider disability, primarily, not as a medical state, but as a form of social, political and economic oppression. These standpoints are illustrated in the two basic models of disability namely the medical and social models. The two models have had the largest hitherto influence on the understanding of disability, and will be discussed in this section.

3.2.1 Medical model of disability

In the early 1700s, England was a nation of about 5.5million people, the majority of whom inhabited rural settlements (Jones, 1998). The country, as with the rest of the UK, was not well developed as a society, and there were hardly any standardized practices (Jones, 1998). Thus, there were no separate groups or categories regarded as different from others, and no expectations that humans would conform to some form of ideal or norm (Davis, 1995). Small-scale businesses and agriculture formed the basis of economic activities, and these were activities that did not particularly exclude individuals with MHCs (Oliver, 1990a). The majority of those who may have been considered different were able to make valid contributions to everyday economies (Slorach, 2011). The transition from feudalism to capitalism, and the advent of a capitalist economy, however, resulted in fundamental changes in social interactions/outlooks, and the nature of work (Oliver, 1990a). The populace progressively became urbanized, and the nature of work changed from rural to industrial. There was the advent of factories, with factory work having more disciplinary regimes and strict time-keeping rules. This form of work differed from the relaxed and flexible approach which individuals with MHCs had adapted to (Ryan and Thomas, 1980). MHCs, therefore, gradually assumed the status of limitation, and came to be regarded in terms of deviation, representing a societal burden (Oliver and Barnes, 2012; Saltes, 2013). This naturally had significant outcomes for individuals with MHCs. They became excluded from production processes, with an increasing number being confined in all types of institutions (Oliver, 1990a), alongside people considered to be miscreants, such as prostitutes and unemployed individuals (Foucault, 2006).

The medical model developed during this era of capitalism, and has largely dominated the conceptualizations of impairment in Western cultures since then (Leclercq-Vandelannoitte, 2011). Initially, the incarceration of individuals regarded as ‘different’ was primarily for ethical reasons (Foucault, 2006). MHCs had no specific connotation, and people with MHCs were simply regarded as ‘different’. Disabled individuals in confinement were not being ‘treated’; rather, these individuals and other inmates were subjected to systematic procedures of physical constrictions as punishment for ‘choosing’ to deviate from ‘nature’ and set norms (Foucault, 2006). Over time, impairments and MHCs came to be characterized via medical discourse; discourse which allegedly aimed to reveal the ‘truth’ about impairments, but, instead, produced and controlled those who came under it (Leclercq-Vandelannoitte, 2011). MHCs came to be regarded not only as deviance, but as a concept in need of medicalized influence (Foucault, 2006), with rehabilitation considered the major means for restoring individuals with MHCs to ‘non-disabled’ standards (Williams and Mavin, 2012). The group tasked with this concern were the medical experts (Oliver, 1990a). Experts gained control over individuals with impairment, and made decisions regarding people’s social/financial lives, based on their perceived functionality.

Under the influence of the medical model, the personal features that impact on employability are highlighted as deficits. Emphasis is on how functionality, stamina, and work-related abilities can be improved through medical means, at the expense of other factors such as organizational behaviour or employee needs (Lunt and Thornton, 1994; Barnes, 2000; Goss et al., 2000; Chan et al., 2010). Fundamental to the model is the notion that disability, as with other social identities such as gender, is found within the individual, the result of functional or biological limitations which necessitate medical opinions and treatment, the implication being that individuals with MHCs are regarded as ‘substandard’ when compared with non-disabled counterparts. The UK society has, over time, taken up this position on the ‘reduced ability’ of individuals with MHCs, and through this, the governance of the medical paradigm is maintained (Barnes, 1990). In history, the perspective has been adopted to validate the manner in which individuals considered ‘different’ are treated, be it in terms of race, gender, ability or age (Sutton, 2012). Medicalized perspectives are also evidenced in the outline

of several studies (Willaims, 2011), in socialized interpretations of disability (Shakespeare, 2006a), and in public policies (Goss et al., 2000). The existing literature on BPD is largely inundated with the medical facets of the condition, with emphasis on the intricacies of depression/mania, types of curative therapies, the social stressors of biological elements, mood stabilizing procedures, attendant conditions including anxiety disorder, managing the condition, and so on (Mandim, 2009). As Nathwani et al. (2015) note, the medical model has had substantial influence on the discourse of BPD, and influences interpretations of the condition, both within and outside of academia.

The medical model has, however, been critiqued for not allowing the consideration of the subjective experience of impairment. The absence of personification and subjectivity is perceived as one of the major weaknesses of the model (Waddell and Aylward, 2010). As Goffman (1963) puts it, medical modellers focus on stigmata and differentiation. The structural and social contexts are not queried, and alternatives to the prevalent medical paradigm are not offered. Difference is either fetishized as medical tragedy, or ignored (Goffman, 1963). This, amongst other critiques of the medical model, led to the instigation of the social model, and served as a catalyst for the disability movement of the late twentieth century, which is examined in the following sub-section.

3.2.2 Social model of disability

Overtime, the individualization of ‘difference’ has been critiqued as insufficient for conceptualizing the experience of disability. The majority of the critiques placed on the medical model were instigated by the disability movement which began in the late twentieth century, and has since grown, encouraging the re-delineation of disability as the product of socialized and structural contexts (Hiranandani, 2005). This movement is representative of the social model of disability, and is examined in this sub-section. The section discusses the origination of the social model, and considers the scope of theorizations of the model, alongside the critiques that have been levied on it.

The UPIAS published an article in 1976 titled 'The Fundamental Principles of Disability', which is often regarded as what set off the development of the social model, and the subsequent theoretical debate and political activities of the 1970s (Fawcett, 1999). The article contested the depiction of disabled individuals by medical 'specialists' as 'different' and re-delineated disability as the oppression experienced by individuals with impairment. After the introduction of this article, academics such as Finkelstein developed a materialist investigation of the segregation experienced by disabled individuals. Finkelstein (1980) argues along the lines of the previous section, and notes how the rise of capitalism resulted in fundamental changes in the structure of work, resulting in the segregation of individuals with impairment. On the basis of his analysis, Finkelstein suggested that the emphasis at the time needed to shift from the intricacies of one-on-one interactions (for instance, between medical professionals and disabled individuals), and medicalized perspectives to the broader social contexts within which individuals with impairment experience oppression. Emphasis for Finkelstein was on redefining disability as a social grouping, a concept which is imposed on top of an impairment, and emerges within the immediate effects of daily experiences of disablism. While Finkelstein's position on the exclusion experienced by disabled individuals has received criticism for not explicitly stating how improvements in the structure of the society will impact on the social response to impairment (Tregaskis, 2002), he, nevertheless, remains recognized as one of the first analysts to highlight the socially constructed nature of disability, and the development of disability within the context of the relations which occur between an individual and the society. Academics such as Thomas (2004c) have referenced Finkelstein's work as moving Disability Studies into a relational realm. According to Thomas, Finkelstein's interpretation of disability positions it as a different type of social oppression, which occurs within the social relations between individuals with impairments and those without. Finkelstein's (1980) delineation of disability went on to have major connotations for disabled individuals, both within and outside the UK, as it motivated the development of the social model. Thomas (2004c) does note that in the process of developing this 'offspring', that is, the social model, the message behind Finkelstein's social relational interpretation of disability was left behind.

The social model came into existence shortly after Finkelstein's seminal work. Oliver, one of the major proponents, drew on the Finkelstein's and the UPIAS definition of disability, and subsequently positioned disability as a function of the society within which individuals with impairments are situated (Tregaskis, 2002). The emphasis for Oliver was on the manner in which individuals with impairments experience segregation due to the structural limitations that exist in the society. Oliver (1990b), alongside Finkelstein, contends with the individualized notions of disability, noting how the emphasis on rehabilitating individuals with 'impairment', rather than altering the nature of the society results in less visibility for the disablist nature of the society. Both modellers consider studies on disability which adopt medical delineations as insufficient and repressive. As Goodley (2011) puts it, to perceive the disadvantages attached to disability as an outcome of physical or 'natural' conditions is to discount the exclusionary role played by social contexts. These modellers, therefore, align with the definition proposed by the UPIAS (1976), which, as noted in the introductory chapter, delineates disability as the disadvantages and limitations that occur due to how the modern society has been designed around non-disability, resulting in the exclusion of individuals with impairment from typical social processes. Hence, at the core of the social model is a conceptual severance of the link between disability and impairment. That is, rather than underscore the individual, the social model emphasizes the role of social procedures and structures in the exclusion of disabled individuals (Saltes, 2013; Jammaers et al., 2016).

The major tenets of the model can be found in several of the studies examined in the previous chapter. The physical structures of the workplace, for instance, as illustrated in the lived experiences of disabled employees discussed in Chapter two, are, to a great degree, constructed around non-disability. The societal norms for such structures have made it such that individuals with 'impairment' may be restricted from the several 'social spaces' that non-disabled individuals take for granted (Hughes and Paterson, 1997). From a social modeller perspective, employees become disabled in these contexts due to the emphasis on having work done effectively by 'the majority, rather than by all employees' (Williams-Whitt and Taras 2010, p.536).

It is vital to note that the social model adopts an ‘issue–resolution’ approach, which involves underscoring the issue and finding a solution to it. The ‘issue’ in this case was how to integrate disabled individuals into the society based on their entitlement to citizenship. The resolution was to instigate the disabled people’s movement of the 1970s, and stimulate the political facets of the movement. The disability movement campaign in the UK, thus, centred on the execution of equal right laws and increasing disability awareness (Fawcett, 1999). This seems to have been successful to a large degree. Social modellists, for instance, contributed to the establishment of the Disability Equality Training (DET) programmes in the UK, designed and offered by disabled individuals in order to provide an avenue for discussions on the potential means for eradicating social and physical limitations (Barnes, 2012b). The model also had some influence on the establishment of the Disability Discrimination Act (DDA) of 1995, and has encouraged redefinitions of disability as a social construct, the product of social outlooks or processes.

Thomas (2004c), however, posits that the very same reasons for its success are what currently stand as the model’s major flaws. Given that the model gained such influence, and was such a vital facet of the disability movement, it, overtime, turned into what Shakespeare and Watson (2001) termed a ‘sacred cow’. That is, it became a dogma, with little room to challenge its basic principles. Discussions on disability were encouraged within the movement, but within these discussions, the notion of ‘impairment’ seemed largely absent. Academics/Writers could only classify themselves as activists where they demonstrated an acceptance of this doctrine that did not incorporate ‘impairment’. Anyone who joined the disability movement had to identify with the ideology behind the model, and accept its characterization of ‘disability’. Disability Studies scholars seemed to regulate texts on disability, and prohibited any text which does not conform to the social modellist standpoint (Shakespeare and Watson, 2001). Morris, for instance, in 1991, wrote a well-known book titled ‘*Pride against Prejudice*’, where the delineations between disability and impairment were not clarified and made distinct. The term ‘disability’ was used in the book at times when, within social model stipulations, she was referring ‘impairment’. Morris also explored the pertinent role played by impairment in the experiences of disability. As a result,

Morris's text was considered by several social modellists within the disability movement as theoretically unconvincing (Shakespeare and Watson, 2001).

This very adherence to the separation of the 'body' and its 'impairment' from 'disability' has resulted in several critiques of the model. As Thomas (2004c) notes, people are often reluctant to assume extreme positions as those found within the social model. It allows the opportunity for resistance, on the basis of how unsustainable it is to refute that impairment causes some limitations. Such emphasis increases the chances of the model becoming a 'straw person'. Disability scholars and activists have, overtime, critiqued the model, asserting that disability is, at times, irrefutably linked to bodily conditions. Criticisms of the model and the responses to these criticisms are explored in the following sub-sections.

3.2.2.1 Critiques of the Social Model

The social model has been widely subjected to criticism and dissension within Disability Studies since its inception (Thomas, 2008). Originally the criticisms were from foremost professional and disability organizations who believed that the control they had over individuals with impairments was being threatened (Oliver, 2013). Oliver notes how this has changed over the years, with several such organizations centering the social model in their organizational processes. Some of the initial supporters of the model and academics who continued to broadly support the model also began to query its efficacy and significance in the years following its conception. Oliver (2013) divides the critiques into two types. First, there are those who criticize the absence of 'impairment' in the social model's delineation of disability. Secondly, there are those who allege that the model fails to take into consideration accounts of diversity; rather, it positions disabled individuals as a uniform group. Some academics argue that this is insufficient, given that other social identities such as age, gender or race may impact on the experiences of disability (Tregaskis, 2002). For the second group of critics, the model is perceived as offering an incomplete and one-sided account of the experiences of disability. The emphasis here is on the first critique, which, according to Oliver (2013), often times seems to have received more attention than the social model itself.

The crux of this critique is on how social modellists, in the bid to shift attention away from the individualized perspective of disability, have focused their energy on the role played by structural barriers in the experiences of disability, to the exclusion of other intricacies of the lived experience of 'impairment' (Pinder, 1997). The model is seen as being averse to the notion of 'impairment' (Hughes, 2000). This perceived theoretical severance of disability from impairment has received heavy criticism, with critics questioning the elimination of the 'body' from social modellists' texts. As Thomas (2004c) puts it, the road between the social model's definition of disability and the suggestion that all limitations are the result of social structures is well travelled. It is vital to note that it is from this 'one-dimensional' perspective of the model that critiques have largely emerged, with several academics challenging the ideology behind the model. The one-dimensional view may, of course, be an inadequate adaptation of the initial UPIAS delineation (Oliver, 2013). Yet, it is this adaptation which became the centre of the debate on the usefulness of the social model, especially for scholars such as Watson and Shakespeare. The critiques resulted in a public discussion in 1996 between these scholars and disability activists, such as Rae and Finkelstein. Some of these critiques are considered here.

Critiques originated initially from disabled feminist scholars who believed that the model dismissed the notion of impairment. Crow (1996), for instance, while accepting the beneficial impact of the model, critiqued it for failing to include the individual experiences of pain, and the restrictions that may occur due to impairment. She notes that the disability movement makes it difficult for individuals with impairment to discuss the possible adverse facets of their impairment, and suggests that the model should be reformed to allow for the inclusion of impairment. French (1993) similarly argues from a feminist perspective for the inclusion of impairment in the social model. She acknowledges the simple and clear-cut message of the social model which emphasizes changing the society rather than the individual, and notes that she is understanding of how the introduction of the notion of 'difference' in relation to impairment may dilute the message of the model, but equally remarks that the total omission of impairment in the model results in the 'bracketing' of impairment, as was initially the case in gendered studies, with 'difference' becoming a forbidden topic,

resulting in an inflexible model. Shakespeare joined in on the critique in 1994. He contends that the social model should be reformed to include, not only issues of oppression, but also the stereotypical assumptions which occur due to the social representations and language of disability. Shakespeare (1994) notes that a re-conceptualization of the model to incorporate both the materialist experiences of oppression and the social attitudes which reflect the representations and language of disability will allow for the much needed inclusion of impairment in its framework. In 1996, Shakespeare further notes that while he supports the notion that structural barriers may disable individuals with impairments, it is also vital that Disability Studies take into account the notion of 'impairment'. He posits that analyzing the discourse of disability may offer a more multifaceted account of disability, and suggests that a Foucauldian perspective may aid in accomplishing this. Here, Shakespeare seems to argue from a post-structuralist perspective, although, as Fawcett (1999) mentions, the extent of his post-structuralism was hindered by the political boundaries of the disability movement at the time.

In 2001, Shakespeare and Watson, again, discussed some of the major issues with the social model with regards to the absence of impairment, and what they termed an 'untenable dichotomy' between disability and impairment. They reason that the social model 'over-eggs the pudding, and risks discrediting the whole dish' (p.15), and suggest that the model should be abandoned, given that its fundamental ideologies has created a framework that cannot be improved on. The crux of the critique, as with previous ones, was the theoretical severance between disability and impairment, and the social model's stance on the disablement of individuals with impairment due to structural barriers as opposed to their 'impairments'. Shakespeare and Watson did challenge the absence of 'impairment' in the model from a different angle. They conceive the severance as indicative of the same correlation of impairment to biology as that found in the medical model (Thomas, 2004c). That is, by rejecting the notion of 'impairment', social modellists demonstrate an acceptance of impairment as biological. They contend that impairment does not fall under biology; rather, it is a social concept. This is more so given that the language and discourse that people use to characterize impairments are social and cultural constructs (Shakespeare and Watson, 2001). From a post-structuralist

inclined viewpoint, both scholars, therefore, position what they term the ‘modernist’ severance of disability and impairment as indicative of the obsolete notions of binary relations. They proposed that the dichotomy between disability and impairment be dismantled. Rather, impairment and disability should be considered as existing on a spectrum, dissimilar sides of the same experience, located at the crossroad between society and medicine. This is partly reflective of the standpoint adopted in this study, wherein impairment is taken to be a discursive construction. The study’s standpoint is further discussed below.

Shakespeare and Watson (2010) go on to critique the model in more recent work, where they note that despite their criticism of the social model, the intention was never to ‘throw the baby out with the bathwater’ (p.58). They, nevertheless, argue that disability and impairment both impact on disabled people’s experiences. From a critical realist perspective, Shakespeare and Watson propose that an acceptable sociology of disability is one that incorporates both the social and medical facets of the experiences of disability. Shakespeare also critiques the model in recent work ‘*Disability Rights and Wrongs 2006*’ and ‘*Disability Rights and Wrongs Revisited 2014*’, on its inflexible nature, and the inadequate consideration given to impairments. He notes from a critical realist position that, on the one hand, the materialist social model is inadequate for theorizing disability due to the absence of ‘impairment’ in its framework; and on the other, the cultural/post-structuralist perspective, which he argued for initially, may also be inadequate given the absence of the ‘realistic reality of impairment’ within its framework. Shakespeare has been critiqued by scholars such as Goodley (2014) for assuming a position of pragmatism, which allows for a compromise between these two extreme positions. The emphasis here, however, is on the critiques of the social model. Social modellists have responded to some of the aforementioned critiques as examined in the following section.

3.2.2.2 Response to the critiques

There have been several responses from the social modellists’ camp to the critiques that have been levied on the model. Rae (1996), in a response titled ‘*Social Model under Attack*’, notes that the debate was caused by a fundamental misunderstanding of the

social model and its position on the difference between impairment and disability. Oliver (1996) also acknowledges that the majority of the critiques have occurred due to the misconception of the social model as a theory for comprehending the social production of disability, while it was only developed to aid in political campaigns for citizenship rights. He underlines the somewhat high expectations that critics seem to have of the model, and notes that the social model was never intended to fully explicate the experiences of 'disability'. Oliver (1996) frequently reminds those who challenge the ideology behind the model that it is a 'model' and not a theoretical explanation – this is not to detract from its influence, as it has certainly mobilized people politically to campaign for disability rights. It, nevertheless, remains a model which simply offers a way for achieving a better understanding of the experience of 'disability' (Pinder, 1997). It was developed as a political tool, as opposed to an academic one, the aim being to rally for the fight and campaign for equal rights.

Oliver, in his response, was unwilling to discard the conceptual separation of disability and impairment, and continues to favour a materialist viewpoint which allows for the analysis of the material/structural means through which segregation occurs. He suggests that this is a vital facet of the model which, if removed, will result in the dilution of the political significance of the model. Hughes and Paterson (1997) affirm this, noting that, to incorporate 'impairment' and admit to pain is to risk 'oppressors' grabbing a hold of what they consider proof that disability results from impairment, thus, re-inviting the medical perspective into the social model. Tregaskis (2002) does critique this notion, noting that the individual experience of impairment is vital in Disability Studies, and maintaining a private/public divide when exploring the experiences of 'disability', or delineating what can or cannot be talked about openly simply allows for and maintains oppression in the workplace/society. Oliver, nevertheless, notes how critics such as Shakespeare and Watson seem unwilling to accept the intended 'descriptive' nature of the model. Rather, they one-dimensionally conceive the social model as delineating disability in relation to structural barriers, and ignoring impairment. Oliver suggests that the devotion to this definition fortifies their continued emphasis on the disabling impact of impairment (Thomas, 2004c), and their critiques of the social model.

Finkelstein (1996), another founding member of the social model, equally continues to support the model. He argues that if the experiences of impairment are included in the analysis of the model, the message of the model becomes diluted, and Disability Studies will return to the same tenets found within the medical model. Finkelstein further notes that the aim of the model is to encourage equality, hence, the attention paid to the society as opposed to impairment. He does accept to some degree that the experiences of disability may occur due to both impairment and structural barriers, but supports the basis of the social model which places disability within the field of oppression, due to the political connotations attached to this delineation. Another academic who agrees with this is Barnes (1996), who remains definite that the role of the social model is to query structural limitations and advocate for change, as opposed to focus on impairments. Summarily, these modellers believe that incorporating 'impairment' into the social model will divide the disability movement and reduce its impact (Fawcett, 1999). Disability academics such as Thomas (2004c) and Hughes and Paterson (1997) have commented on the social model debate, noting how it ensued due to the emphasis on one angle of the social model. The notion adhered to by several scholars and activists is that the social model positions impairment as having no impact on individuals with impairment. Thomas suggests that this one-dimensional view of the model made it into a 'straw person' that was easier to counter, given that 'impairment effects' are undeniable. She notes how this inadequate interpretation of the model has unfortunately become the crux for the criticisms levied on the model, particularly for academics such as Watson and Shakespeare

The debate was beneficial as it gave a distinct scrutiny of the rationale behind the social model, and the limits of the model. This offered valuable transparency for academics that adopted and continue to adopt the model for exploring the experiences of 'disability'. The adverse effect is that it has resulted in shifting attention, almost solely, to the question of what constitutes disability, either impairments or structural barriers. This suggests an exclusion of other means for theorizing disability. As Thomas (2004c) puts it, the debate is probably part of the reason why alternative means for understanding disability, such as social relational means, have remained less researched. However, as noted in the introductory chapter, the debate on researching 'structural

barriers' versus 'impairment' may well have been defensible during the 1990s, when the social model was somewhat still in its developmental stage, but perhaps the time has come to shift focus to theorizing the adverse perceptions which exist in the workplace/society, and how these inform and maintain ableism in the workplace. This is not to discredit the social model, as it has been an influential and political organizing model which aided in rallying people for the disability movement. The impact the model has had in creating awareness and propagating equality is undeniable (Tregaskis, 2002). There is, nevertheless, the need to acknowledge the restrictions of the social model for theorizing disability, and accept, like Finkelstein and Oliver did, that the model is simply a 'descriptive' tool that cannot fully explicate the experiences of 'disability'. Hence, even as scholars continue adopting the social model, perhaps there will be benefits to extending the model to explore the reasons why ableism continues to occur both in the workplace and society. Indeed, perhaps some of the initial questions that remain unanswered by the social model with regards to the experiences of social exclusion may be addressed by underscoring the ableist social interactions that aid in maintaining such exclusion. This study adopts a model that allows for such analysis, an extended version of the social model, namely the social relational model. The social relational model aids in attaining a relational understanding of the socially constructed nature of disability, as discussed in the next section.

3.3 Social relational model

At the crux of any disability research is the question of either focusing on the experiences of impairment (impairment effects), or on the social processes that disable individuals with impairment (Ferrie and Watson, 2015). Studies that adopt the first align with the medical model, while the second is related to the social model. Thomas (1999) proposes a third model, a modified version of the social model, which she terms the 'social relational model'. Disability is defined in the model as the disadvantages experienced by individuals with impairment which is socially imposed, a function of the imbalanced social relations that occur between individuals perceived as 'different' and those perceived as 'normal'. Thomas (2004c) notes that this perspective of disability as the function of disadvantages which are socially imposed is reflected in the original

social relational interpretations of disability in the UPIAS article, and in Finkelstein's (1980) work. It has simply gone unnoticed due to the birth of the widely proclaimed 'social model'. According to Thomas, adopting this perspective will probably aid in reducing the amount of time spent on debating the origin of disability, and help shift emphasis from the social model, which itself obscures other theorizations, to analysis such as the deconstruction of the term 'disability'.

The social relational model, as adopted in this study, considers disability, as with any form of difference, to be the sum total of socially constructed limitations, and the particular social interactions that impact on the self (Thomas, 2004a). The model points to how, aside from the structural restrictions placed within the social model, individuals with BPD may also face social reactions from people, and may be disabled within the context of social interactions with, for instance, friends, family, colleagues, managers, or even medical specialists (Thomas, 2004b). Disability occurs within the context of such reactions, and is conceptualized as the quality/product of social relations. As Thomas (2004b) puts it, disability is a product of the interactions between individuals who have been socially constructed as different from the norm, and individuals who meet the socialized criteria of normalcy. In essence, the social relational model presents 'difference' as the outcome of social interactions. The basic premise of the social model, that is the severance between disability and impairment, is maintained, but there is more emphasis on the elements of oppression than on the 'disadvantages' which result from impairments (Reindal, 2008). The social relational model is, for this reason, two-faceted. First, the model acknowledges the ableism which occurs due to the normative construct of work. Work is taken as constructed around non-disabled norms which position BPD employees as incapable of work. Secondly, the model depicts how ableism is maintained within social relations, with resultant effects on the sense of self. Having discussed the first facet to some degree in the previous section, this section focuses on the second facet, that is, the relational nature of disability and its impact on the sense of self.

Social relational modellers delineate disability in relation to non-disability. Disability is taken to be produced and maintained as the 'other' via social interactions and discourse,

in relation to non-disability as the ‘one’ (Williams and Mavin, 2012). Such analysis introduces notions of non-disabledness into conceptualizations of disability, underscoring it as a standard within contemporary organizations. It allows for the consideration of the constructions of non-disability in discourse as ‘normal’, relative to disability (Williams and Mavin, 2012). The study takes the position that the social relations which institute disability are similar to the relations that institute gender. That is, notions of ‘masculinity’ and ‘femininity’ are established within social spaces (Connell, 2011). While the resulting concepts may vary over time in relation to context, they are often moulded around notions of masculinity as the preferred option. This suggests that gender, as with race or class, may occur within relations which are influenced by the notions of ‘difference’ (Connell, 2011). The social relational model allows for such intersections with other social identities. It is vital to note the possible interconnectedness (between gender and disability) within the context of the study, given the emergence of this interconnectedness in the data collected.

The disablement that results within social interactions often impact on the sense of self, and may lead to the development of limitations within, rather than without the self. The social relational model accommodates this micro-level form of disablement, and integrates the impact on the self with the emergence of disability within social interactions. Reeve (2002) refers to the impact on the self as the psycho-emotional facet of disability, or internalized ableism. According to Reeve, internalized ableism could be more difficult to address given the in-depth rootedness within the self. The concept is further examined in the next sub-section.

3.3.1 Internalized ableism

Thomas (2006) posits that disability occurs on a psycho-emotional level via relational means, personified in the experiences of pity, being stared at, dismissal, and belittling responses from non-disabled individuals, which often result in feelings of worthlessness and insignificance. The sense of self develops within such social contexts, which impact on the social views of the self, be it gendered, familial or organizational (Reeve, 2002). Put simply, social relationships are vital for establishing a sense of identity, and the feeling of being ‘accepted’ within social settings is a vital contributor to the self-image.

A person's sense of self may, therefore, be reliant on the stigmatized perceptions received from others, and the experiences they have within social spaces. Individuals with observable conditions, for instance, often experience stares from people in public spaces, which can have psycho-emotional impact (Goldberg, 2012). The experiences of social spaces probably differ for individuals with BPD, given the invisible nature of the condition. Nonetheless, the continuous fear of discovery may impact on the sense of self (Thomas, 2004b). Besides, where BPD is disclosed, the reactions and responses received from colleagues and friends can result in 'disability', with resultant effects on the sense of self.

This suggests that BPD individuals may be disabled within the context of being perceived and labelled as different (Campbell, 2012). The internalization of public perceptions could result in BPD individuals positioning themselves as incapable, and emplacing personal limits (Simpson et al., 2013). According to Reeve (2004), the disablement which occurs within such contexts is more pertinent when considering invisible conditions like BPD, given the reduced impact of physical limitations on individuals with the condition. The adoption of the social relational model in the study, therefore, offers a new perspective on the experiences of an invisible impairment.

The theoretical challenge is to comprehend how interactions are established/sustained, and the particular means through which social reactions are shaped. As Fawcett (1999) notes, there may be different means for engaging and developing the understanding/theorization of disability as occurring within social relations. Hence, having delineated the model adopted in the study in this section, the following sections examine the theoretical perspectives often adopted for conceptualizing disability, and delineate the stance adopted in this study for conceptualizing BPD.

3.4 Theorizing disability

Critics of the social model have called for a more in-depth analysis and theorization of issues such as diversity, difference and impairment. The model, itself, has subsequently been theorized in different ways, the majority of the time from the modernist, structuralist and materialist standpoints (Tregaskis, 2002). There continues to be the call

for further theorization and the development of strands in Disability Studies to examine issues such as the role played by discourse and culture in sustaining the notions of 'deviance', and producing the experiences of exclusion for individuals regarded as the 'others' (Tregaskis, 2002). As argued by scholars such as Shakespeare and Watson (2001), the pure materialist nature of the social model devalues pertinent influential factors such as language and culture in disability analysis. These scholars argue that social identities, such as gender and disability, are the products of social processes and discourses that are passed on from one generation to the next (Kitchin, 1998). According to Barnes (1996), perhaps the time has, therefore, come to perceive the modern social response to impairment as a construct of the interactions between the society and its 'standards'.

This study adopts a post-structuralist perspective, which allows for such analysis of the discursive contexts within which the connotations of disability as 'difference' have been shaped, as it is these that inform social attitudes and behaviour. The perspective adopted is somewhat representative of the aforementioned arguments by Shakespeare and Watson (2001) on deconstructing the dichotomy between disability and impairment, and incorporating an analysis of the social attitudes which reflect the representations and language of disability. Post-structuralists challenge the traditional means for theorizing disability. Academics from this standpoint interrogate language, social classifications, discursive practices, and the particular means through which notions of normalcy and difference are constructed, alongside the power that such classifications have on the construction of subjectivities (Fawcett, 1999). It is, however, vital to note that even though the study acknowledges impairment, the study does this in terms of the materiality of discourse. In essence, rather than argue that impairment can result in disability, or disability can aggravate impairment, as Shakespeare and Watson do, the study acknowledges impairment in terms of the materiality of discourse. The body is taken to be the product of social practices and a discursive construct. Language is considered the medium through which the society makes sense of the body and impairment; it impacts on how an impairment is understood and responded to, and the resultant experience of the 'impairment' for the individual. The study, thus, adopts the

position that the particularity of ‘impairment’, or BPD in this case, as a concept has been built via discourse.

The following sections further discuss the social constructionist perspective, which sets the context for the subsequent discussion on the study’s theoretical stance, namely post-structuralism. Both standpoints reveal, to a large extent, the limits enforced on the ‘self’ by social roles and standards, and are both suited to the social relational perspective of disability.

3.4.1 Social constructionism

The social constructionist view developed as a viewpoint from work done by Foucault (1972), Jodelet (1991) and Durkheim (1963), among others, who analysed notions of ‘difference’ as the function of socialized procedures. Social constructionists take the stance that the entirety of the world is constructed, including the little things, such as the taste of food (Anastasiou and Kaüffman, 2011). Anastasiou and Kaüffman (2011) cite the example of the concept of child labour and how the understanding of the concept has changed from during the Industrial Revolution when it was considered the norm to current times where it is a controversial issue. Social understanding has changed in relation to the changing discourse around child labour. When applied in relation to BPD, this suggests that the label of BPD does not connote pathology or an individual’s physical self. Rather, it is a product of the construct of normalcy, a construct which is relative to the environment (Soder, 2009), and exists as an artefact of knowledge which appraises deviations from the norm (Tremain, 2005). Hence, BPD results in disability due to socialized normalizing notions (Bunge, 1996). This perception of disability is principally pertinent to BPD, given that individuals with the condition are usually delineated as different due to ‘observed’ behaviour during episodes. If, for instance, these individuals were to behave differently in isolation, their behaviour would probably not result in delineations (Sandle, 2012). Besides, the same way one could argue on the weight that constitutes ‘obesity’, one could argue for the degree of ‘happiness’ that constitutes a manic episode (Anastasiou and Kauffman, 2011). BPD is taken to be a social construct in the current study (Mandim, 2009). The next sub-section further considers the delineation of BPD as ‘difference’ relative to the norms of non-disability.

3.4.1.1 Construct of norms

Contemporary society is preoccupied with the construct of normalcy. As Davis (1997) puts it, 'norms' have become a standard in the contemporary world. Everyone strives to meet norms, taking into consideration how the regular person acts, thinks, works, or even eats. People are born into such normative contexts, and 'socially learn' to differentiate the norm from the 'others'. Photographic studies have long since portrayed that children do not begin responding adversely to 'difference' till they are about eleven years of age (Abberley, 1987). Reactions and behaviour towards individuals who look or act different is, thus, not due to an inborn sense of the conception of difference. Rather, it has been socially learnt. This relates to how people are primed for pre-set gendered roles from a young age (Collinson, 2003). According to Mills (1997), people are taught from a young age the implications of differences in gender, and the different expectations attached to gender. Particular prospects may be offered to one gender over the other, or particular behaviour is encouraged/discouraged for specific gender. Women, for instance, may be guided in the direction of the set roles of parent and wife, while men are positioned as 'breadwinners'.

Normality is, this way, rooted in the very discourse and principles that constitute the fabric of human life. This results in an ableist belief which incorporates the notion of standardization (Overall, 2006; Olsen and Martins, 2012). Non-conformity is associated with deviance, and where people deviate, such individuals are considered as different from the norm. Individuals may, for this reason, go to great lengths in order to conform to social norms. Park (2000) highlights this in a study investigating the intersections between an invisible condition (haemophilia) and gendered expectations. The study adopts a mixed-method approach, with a combination of surveys and observation. Male participants were found to emphasize conformity to the gendered expectations intrinsic in the involvement in rugby, a socially accepted representation of manliness in New Zealand, in spite of haemophilia. The participants discounted medical implications in the bid to conform to masculinized norms, with resultant effects on the self. These notions are equally reflected in studies such as McDowell and Schaffner (2011), where findings point to the incongruence between femininity and American football. American

football was considered contradictory to feminized discourse. Similar studies point to the lengths people are often willing to go, in order to evade perceptions of difference. This is more so where impairment is invisible, as with BPD. Where a woman decides, for instance, not to have children, or to work part-time, she may experience adverse social response due to the perceived deviation from standard expectations (both gendered and ableist), deviations which have been brought on due to a condition that is invisible, and may be undisclosed.

The organization and significance of work and of the employee are equally constructed around normative notions. Contemporary workplaces are rife with gendered (and ableist) practices, wherein delineations are made between individuals who fit norms and those who do not (Acker, 2006). According to Acker, work in contemporary organizations is largely structured around the concept of a white male, who is completely dedicated to work. This suggests that work is organized around roles that preclude any form of difference, and consists largely of restrictions of different sorts, with suppositions of capability and flexibility (Hall and Wilton, 2011). The workplace can, therefore, be a key site for the construction of BPD as 'difference'. Normality is, in this sense, delimited by the notion of the 'non-disabled male' who is presumed to have a physical advantage. Any other form of body is regarded as hierarchically inferior (Hiranandani, 2005). The embeddedness of ableist and gendered norms in the workplace has consequential effects on thought and behaviour (Cherney, 2011), manifesting via attitudes which differentiate or devalue perceived deviations from the norm (Campbell, 2009). It results in the shaping of social reasoning around the types of physical or mental abilities which are respected in organizations (Overall, 2006), with adverse significances for BPD employees. The experiences of BPD in the workplace are a product of these constructs of norms (Acker, 2006).

This section examined the social constructionist perspective of disability. Emphasis was on the role of societal/organizational norms in delineating the 'norm' from the 'others'. The section underscores that gender and disability are the constructs of social norms, and the product of prevalent standards (Carlin, 2011). Both qualities have come to be associated with less valuable skills in the workplace, due to the social understanding of

the qualities as deviations from non-disabled/male norms (Acker, 2006). Relating this to BPD, the study suggests that BPD is delineated as ‘different’ from the norm via discursive means, resulting in the experiences of disability. In essence, individuals with the condition may not experience ‘disability’ in the absence of socially produced limitations. This surmises the theoretical underpinning of the study, and contextualizes BPD within disability studies. The degree to which ‘difference’ is considered a social construction is, however, largely dependent on the epistemological stance adopted in the study. Attention turns, in the next section, to the perspective adopted in this study, a ‘stronger’ form of constructionism, namely post-structuralism (Siebers, 2001). This perspective is of particular benefit, as it relates BPD more directly to the social context. Post-structuralists probe further into social constructionist claims by highlighting the role played by language in constructing meaning. As Shakespeare (1996c) notes, an examination of the language of disability offers a richer and deeper perspective into the concept of disability.

3.5 Post-structuralism

The post-structuralist perspective is often related to the work of Foucault and Derrida. Both philosophers, as with other post-structuralists, challenge prevalent notions of a sole reality. Post-structuralists avoid positivistic perceptions of a pre-fixed reality, or pre-fixed binaries, highlighting, instead, the unsolidified and transitory nature of ‘reality’ (Thomas, 2004b). Nature is taken to be the product of language, with thought itself limited outside of language (Kristiansen et al., 2009). Binaries such as ability/disability or masculinity/femininity are considered the effects of discourse, and the constructs of language. As Crawford and Mills (2011) put it, people can only say what language permits them to say, and to define a thing, is to establish its existence (Hughes and Paterson, 1997). In addition, the Foucauldian perspective theorizes notions of subjectivity, power and knowledge. Subjectivity and the sense of self are taken to result within discourse, with the self considered ‘unfixed’. Having adopted this perspective, the study positions experiences of BPD as ‘disability’ to be a function of available discursive practices, rather than an expression of reality. Language and

discourse form the basic concepts of this standpoint, and are discussed in the following sub-sections.

3.5.1 Language and control

Post-structuralists posit that experiences, both conscious and unconscious, are interpreted through language (Hassard et al., 2000). The way people experience 'life' is intricately connected to the way they converse about it (Flynn and Lemay, 1999), and accounts of the social realm can be found, not in physiques, but in the linguistic domain within which physiques interact (Shakespeare, 1998). In essence, the terms and names given to an impairment ultimately impacts on peoples' experiences of the impairment. Language/meaning is, however, not ours to determine, else people would be unable to converse with each other (Belsey, 2002). Indeed, language, if not used properly by applying extant connotations which existed before people's knowledge of it, will not result in successful conversation. But, to apply connotations in a precise, pre-determined manner is to reiterate the standards which have been set by preceding generations (Belsey, 2002). Language, therefore, controls people; it necessitates conformity to some form of order. More importantly, language maintains governing ideals and social organizations (Crawford and Mills, 2011). It is entrenched within the diverse contexts of collective principles, assumed orderings, and preconceived notions, which guide how individuals construe and understand their experiences (Crawford and Mills, 2011). A pertinent illustration is the way specific groups of MHCs have been constructed by mental health experts in the Western world (particularly the USA), which are promoted through the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Watters, 2010a; 2010b).

The DSM manual is used as a guide, globally, for diagnosing MHCs (Watters, 2010b). In order to be diagnosed with an MHC in several nations, an individual often has to display symptoms that match defined standards (Lea, 1988) in the manual. Through the text found in such manuals, Watters (2010b) posits that Americans have homogenized the manner in which the world experiences MHCs. A psychiatrist in Hong Kong, for instance, once noticed that anorexia manifested different symptoms in the city compared to presentation in the USA, symptoms that seemed to be culturally specific to Hong

Kong (Watters, 2010a; 2010b). The presentation of symptoms in Hong Kong, however, changed in 1994 as a result of the highly publicized death of a teenage anorexic girl. In trying to make sense of the death, medical professionals in Hong Kong referred to the DSM. In the process, the DSM's version of anorexic symptoms became public knowledge. As soon as this occurred, the presentation of anorexia amongst patients in Hong Kong changed to fit the criteria set out in the DSM. For medical professionals, using the definitions of anorexia as stated in the DSM made it easier to ignore differences in the way the condition was being experienced. Several simply generalized symptoms to fit set standards. In essence, it was not anorexia if it did not conform to the criteria stated in the DSM. With the introduction of a new set of definitions, and the use of new language, cultural effects on anorexia in Hong Kong were abandoned. In addition, once the condition was given a name, and people became aware of it, there was an increase in its prevalence amongst the population. Consequently, not only was the language of anorexia in Hong Kong altered, experiences of the condition itself changed (Watters, 2010a), to fit the newly introduced language.

Connotations, therefore, develop within the context of the language adopted for describing a phenomenon (Hughes and Paterson, 1997). The persistent use of language produces a precise type of body/mind, with the fitting behaviour and symptoms. Language, then, does not merely define, it could also disable. People categorized as fitting the criteria set out in DSM manuals, for instance, are perceived as having specific attributes that distinguish them from those considered 'normal' (Lea, 1988). When a child is 'given' the label of BPD, in correlation to set criteria, some expectations are created of how the child will perform in life (Grenier, 2007). The child is expected to deviate from standard guidelines for what is considered suitable behaviour, guidelines set via the use of ideologies. The child's life experiences would often eventually conform to these expectations. Post-structuralists do acknowledge that the presentation of conditions such as cancer will probably not change due to how people converse about it (Watters, 2010a). The symptoms and experiences of MHCs such as BPD are, however, unavoidably linked to the use of language within social relations, both within the society and the workplace (Watters, 2010a). Language does not accomplish such

influence on its own. It assigns meaning to objects and experiences via the use of discourse. Discourse is examined in the next sub-section.

3.5.2 Discourse

Language cannot incite significance by itself, it relies on an extant structure, which defines and relates words to each other (Foucault, 1972). An uttered statement needs to be inherently linked to an existent field of knowledge that offers some form of structure (Fadyl et al., 2012). In the absence of this structure, words have no meaning (Foucault, 1972). The structure through which language gets to have significance is referred to as discourse. Discourse is the space where ideas and language transform into ‘truths’ (Erevelles, 1996). It is the space where language can be employed to create diverse authoritative constructs (Erevelles, 1996). Words are organized in a specific manner within discursive spaces; terms are selected amongst other terms, in order to give specific meaning (Fadyl et al., 2012). The concepts of ‘normalcy’ and ‘difference’ have, for instance, been structured in specific relation to each other, to give meaning to humans. Lawson et al. (2013) affirm this in their study, noting that the definitions of diversity in policies in England infer some form of deviation from ‘normalcy’. According to Lawson et al., it is through these constructed definitions that difference is produced and assumed within a framework of normative notions. Fadyl et al. (2012) equally note that the concept of workability has been defined such that people understand it in terms of specific capabilities, which an individual needs in order to work. Some notions are underscored, while others are omitted. Fadyl et al. (2012) refer to this as the process of exclusion, whereby discourse indicates signification. The power of signification is inherent in the elusive, inescapable, and established manner through which discourse modifies and legalizes routine actions (Zanoni et al., 2010).

In relation to disability, Hedlund (2000) posits that discourse evolves through debates regarding the definitions of disability. The resulting discursive framework offers an understanding of disability, and facilitates how it is conceived and responded to. Normative notions in the workplace are, this way, established via discourse, consequently opening up room to define employees who are ‘different’. In essence, the standards for what is accepted as normal are not given, rather, they are conversed in

space (Swain et al., 2004). What exists is a lingual pattern of normative discourse, which transmits information to humans about bodies, and helps them to understand what it entails (Swain et al., 2004). As members of an organization shape and get shaped by such discourse, conditions are set for 'deviations' (Holmes, 2006). Employees inadvertently draw from this discursive resource, in the process of negotiating the workplace (Wright, 2003). The adoption of specific connotations over others, however, reflects an element of power, wherein power revolves around the meanings and measures used in establishing social realities. The possible influence of power within discursive practices is examined in the next section.

3.6 Foucauldian perspective of power

Power is a vital facet of organizational theory, and has been theorized from several perspectives. Lukes's (1975) power dimensions provide a succinct overview of the types of power that exist. The first dimension refers to the form of power that pushes people to do what they typically would not do. The second is the form of power which manages the situation, and devices means via which the possibility of making adverse decisions can be forestalled. This form of power is related to the social model's conception of 'oppression', wherein power is considered a part of the socio-cultural framework that transforms impairment to disability. The final dimension involves the form of power which influences human awareness and views (Gabriel, 2008). Power, in organization studies, is often studied with regards to managerial control, inherent in the first two dimensions of Lukes's analysis. Both forms of power are found in the history of organizational theories, such as Taylor's scientific management theory, and Weber's bureaucratic principles. Weber (1924), for instance, interpreted power as dictating ones will over another, in spite of resistance. Post-structuralists, on the other hand, emphasize the manner in which particular knowledge systems become engraved on peoples' sense of self. This form of power, inherent in the third dimension of Lukes's analysis, is increasingly being adopted via indirect means (Holmes, 2006). It is usually found rooted in organizational systems/beliefs, operating via social relations and linguistic constructions which are regarded as the norm. This perspective of power forms a focal point of analysis in Foucault's work, and is vital to the analysis of the discursive

constructions of BPD in the workplace in this study. It is, however, vital to note that the Foucauldian analysis of power allows for resistance and agency, which is not found in Lukes's third dimension of power.

Foucault is one of the prominent scholars in the theorizations of 'difference', and its construction in relation to knowledge and power, as opposed to biology or medicine. His work has been used in disability studies for conceptualizations of the sociology of the body, and for deconstructing binaries of impairment/disability and non-disabled/disabled (Fawcett, 1999). The Foucauldian conception of power contrasts with traditional conceptions of power. Indeed, Foucault (1977, 1980) questioned prevalent conventional notions of power as the possession of a higher authority, proposing, instead, a form of subtle power. In the place of inflexible and autonomous forms of power, he underscores the regulatory effects of discourse (Foucault, 1972), which inherently moulds subjectivity. He highlights how discourse operates on the body, inscribing, regulating and controlling it, and was particularly interested in how this form of power operates (Foucault, 1980). This is evidenced in the majority of his work. For instance, Foucault discusses in *Subject and Power* (1982) how corrective systems operate on bodies via panoptive techniques. He further highlights this in *Discipline and Punish* (1977), noting how surveillance systems influence the behaviour of the people being observed. He suggests that such systems result in the 'othering' of particular individuals on the basis of 'difference'. Foucault's work generally points to how subjectivity to discourse may occur due to discursive influences.

The ontology of this perspective of power questions how employees may come to acknowledge and present themselves as 'subjects', complying with set standards and principles (Tremain, 2005). This raises the question: how and why will BPD employees submit to the influence of power? Foucault's analysis of knowledge, power and subjectivity aids in clarifying this.

3.6.1 Power, knowledge and subjectivity

The notion of subjectivity forms a vital part of the scholarship on discourse in the workplace (Bergström and Knights, 2006). Subjectivity, in this sense, connotes

subjection to the influence of power and discourse (Foucault, 1980, 1982). Foucault (1972) posits that contemporary systems of power are essentially linked to knowledge. This is why prevailing and influential societal discourse often has strong knowledge bases, such as law or medicine (Crawford and Mills, 2011). People interpret their actions, and that of others, by making reference to these forms of knowledge (Foucault, 1972). The major source of influence on people's understanding of BPD has come from the scientific/medical discourse and knowledge (Shaw, 2007). This knowledge provides a basis for delineating BPD individuals as different, and underscores their need for 'management'. It carries over into the workplace, influencing organizational practices. HRM processes such as appraisals and performance reviews, for instance, offer some form of lexicon and knowledge, a technique for making BPD employees become knowable and governable (Townley, 1993). These practices are underpinned by normative measures, and may highlight how BPD employees vary from the norm. The knowledge produced within HRM practices, in turn, influences the thought processes, self-realization, and motivations of organizational actors (Baratt, 2002). Different forms of employee identity, disabled or otherwise, are constructed through these means.

Subjectivity occurs within these interactions between knowledge and power. According to Foucault (1980), it occurs due to discourse's ability to enter into people's thoughts, insidiously regulating those who accept it as truth (Foucault 1972; 1977; 2001). One of the major means for achieving this is via systems of normalization. Foucault (1982) posits that normalization techniques have replaced previous judicial systems which operated on the basis of domination. Under the influence of normalization, people internalize expectations with resultant effects on lived experiences. Normalization demands conformity to norms, and homogeneity (Gabriel, 2008). In the bid to ensure compliance, normalization techniques are employed for shaping, normalizing, and influencing the behaviour, thoughts, and ambitions of people (Knights and McCabe, 2003). Power relations occur in this process of separating, measuring, matching and segregating people (Collinson, 2003).

Normalization techniques operate in the workplace via diverse means (Ahonen et al., 2013). Several organizational practices construct controlled and regularized selves

(Collinson, 2003). As aforementioned, modern organizations monitor employees' performance via HRM practices. These practices adopt individualistic techniques, such as performance reviews, in order to manage and measure productivity, thus, progressively separating employees into distinct individual units, and strengthening normative measures of productivity (Knights and McCabe, 2003). These conventional techniques for organizing and regularizing work could restrict human reasoning, constituting subjectivity to the influence of power. The evaluations and assessments result in some form of surveillance, which renders employees predictable, making them into compliant beings who partake in their own relegation (Collinson, 2003). Employees' understanding of themselves inadvertently becomes moulded by the normative ideologies that underpin workplace processes (Gilling, 2012). Disabled employees could come to accept and understand why they receive less wages compared to non-disabled counterparts, due to the perceived differences in productivity and idealized averages. Procedures of normalization can, this way, influence the manner in which employees experience work. This form of subjectivity results in unchallenged notions of normalcy and deviance.

It is vital to note that Foucault positions subjects as taking part in their own subjection, and submitting reflexively to influences of power (Foucault, 1977). As Bergström and Knights (2006) observe, people become subjects, by taking part in discursive processes, which have been conditioned through the influence of knowledge and power. In the process, they develop an understanding of reality that they adhere to. Such subjects, therefore, have some form of agency, even where they learn to define themselves within a set limit of delineations (Foucault, 1982). Power relations within organizations could, thus, connote identity regulation (Alvesson and Willmott, 2002; Nentwich and Hoyer, 2013), a process whereby BPD employees' individualities become the products of the interactions between knowledge and power (Holmqvist et al., 2012). This relates to the social relational model's psycho-emotional dimension, as the influence of discursive power within the context of social relations does not only operate on BPD employees by restricting and regulating them, it equally infiltrates the sense of self, establishing employees as subjective entities (Maravelias, 2009).

Having adopted the post-structuralist standpoint, this study critiques the existence of these invisible standards related to ability, and underscores how particular social identities come to be regarded as deviations via discourse which valorizes ability (and masculinity), but relegates disability (and femininity). Emphasis is on how particular people become relegated due to ableist and gendered notions of difference (Amsterdam et al., 2015). BPD is considered a product of discourse, that is, a label which serves as a form of regulatory structure, influencing behaviour, connotations and sense of self (Leclercq-Vandelannoitte, 2011). Social responses to the condition develop within discourse, which is largely embedded in the society. As Jammaers et al. (2016) note, ableist practices are replicated via linguistic systems and discourse. Aside from acknowledging the socially constructed nature of BPD experiences, the study also explores the influence of Foucauldian forms of power on BPD employees' subjectivities. Adopting Foucault's work should aid in developing insight on the vital role of discourse in the constructions of BPD as 'difference' in the workplace. It is vital to note that the study does not deny the realism of the individual experiences of BPD (Willmott, 2005). Rather, the study underscores the materiality of discourse. Language is considered to be entrenched in the materiality which comprises the personification of humans, in addition to the world of objects. Willmott (2005) succinctly illustrates this, noting that an earth tremor, for instance, cannot merely be 'discoursed' out of existence. However, its particularity as a phenomenon is produced via the discourse which creates it. Thus, the existence of themes external to thoughts is not refuted, rather, from a post-structuralist standpoint, the study claims that these themes cannot be established as themes outside of discourse.

This section underlines how subjectivity occurs, and power influences remain invisible in the construction of normative notions within the workplace. The section positions notions of normalcy as the means through which power relations surface and are legalized (Foucault, 2003a). The fundamental ideology behind the notion of normalcy is that of qualification and rehabilitation. Employees can only be effectively supervised when characterized and engraved with assessable features. The features naturally reflect non-disabled ideals. For this reason, BPD employees may be regarded as 'different' and in need of rehabilitation. The segregation of individuals with the condition, then, is a

product of the operations of knowledge and power. Employees can, however, equally resist the influence of power. As Foucault (1978) states, wherever power exists, there is usually some form of resistance, it is an integral facet of power relations. Thus, while employees' identities may be shaped by power interactions, employees are not always unresisting of these influences (Holmqvist et al., 2012). Procedures of resistance are examined in the next section.

3.6.2 Resistance: Deconstruction of linguistic constructions

Negotiations occur within power influences, which result in agentic action. Amsterdam et al. (2015) note the need to examine such agentic actions, as they may depict the means through which ableism can be reduced. This section briefly underscores the possibility of resistance of discursive influences.

Even though power influences have regulating effects, which can become assumed by individuals, they can also result in resistance (Shildrick, 1997). Discourse often plays the dual role of sustaining power on the one hand, while obstructing it on the other (Foucault, 1978). A major point of resistance in disability studies, for instance, was the introduction of the social model perspective, which challenged prevalent individualized definitions of disability (Reeve, 2002). Another example is cited in Knights and McCabe's (2003) study, where employees were found to oppose the domineering discourse of teamwork in their workplace. Processes of power may, therefore, offer and reinforce specific forms of workplace experiences for employees' uptake, but these can be repelled by employees. As Foucault (1978) puts it, while discourse constructs and underpins power, it could equally challenge it. Foucault refers to this as the process whereby discourse is made overt by extending its margins. For Foucault, in the absence of such resistance, there is no power (Foucault, 2000). The emphasis in the chapter, thus far, has been on BPD and disability. As aforementioned, the primary focus of the research is 'disability'. Gender relations, however, emerged within the theoretical analysis of the study's findings. The next section, therefore, delineates the manner in which gender is conceptualized in the study.

3.7 Conceptualizing Gender

The medical model, when applied to gender, places emphasis on biological essentialism and genetics (Connell, 2011); the same way the model positions ‘disablement’ within the individual. Gender is related to an individual deficit, and is perhaps even more individualized than impairments (Travis, 2015). Medicalized perspectives have resulted in the notion of women as ‘different’ from the ‘norm’. Travis (2015) underlines this, noting how the reasons for the extant pay gaps between men and women are placed on women who are perceived as unable or unwilling to bargain successfully for equal pay. According to Travis, such notions have become embedded in legislation and policies, resulting in the propagation of medicalized interpretations of gender. Again, the social model, as found with disability, counters such notions, and distinguishes between sex and gender. From a social modellist perspective, gender is considered the product of social influences (Shakespeare, 2006b). The social model, when applied to gender, shifts social emphasis from the ‘self’ to the role played by the context of work in producing discrimination for women in the workplace. Having adopted the social relational model in conjunction with a post-structuralist perspective, this study is inclined towards the social modellist perspective of gender. Hence, rather than consider gender to be rooted in the body, the study takes gender to be a social product (Shakespeare and Watson, 2001).

Particular attention is paid to how gender occurs within discourse, as set via social relations. In essence, both social and gendered dichotomies are considered the products of discourse, rather than reflections of the ‘self’ (Connell, 2011). Taking it further, the study suggests that gendered notions are replicated and sustained within social interactions. As aforementioned, people are taught from a young age what is socially acceptable on the basis of gender. These gendered roles are set within discourse, and sustained by social groups such as the family (Connell, 2011). When integrated with other social identities (for instance, race or class), they mould and determine self-perceptions, and also influence social response to ‘difference’. As Ridgeway and Correll (2004) put it, differential treatment, be it on the basis of race, gender, or impairment, is often a function of discourse, and is replicated via social relations. An individual’s

perception of what is socially acceptable may, thus, impact on the sense of self, and on the individual's behaviour and reactions to difference. Similarly, it is within the context of social interactions that individuals learn to identify in relation to the people around them, and come to accept that they will be treated differently on the basis of set norms (Ridgeway and Correll, 2004). The study places emphasis on the manner in which particular social identities are deployed as 'deviations' via discourse, and sustained within social interactions. Both gender and disability are conceptualized as social processes, produced via discourse. The final section of the chapter ties together the model adopted in the study and the theoretical stance taken. The section considers the relationship between the social relational model and the post-structuralist perspective.

3.8 Post-structuralism and the social relational model

Having merged the social relational model with a Foucauldian post-structuralist standpoint, it is vital to note the critiques that have been levied against the model from the post-structuralist perspective. According to Thomas (2004c), several academics perceive the social relational argument that disability occurs in the interactions between disabled and non-disabled individuals as an affirmation of the positivistic claims of social classifications, and binaries of ability/disability. That is, the social relational model is receptive of the existence of a pre-fixed reality, and pre-fixed binaries of the 'norm' versus the 'deviant'. Post-structuralists, in contrast, often evade such positivistic perceptions, underlining, instead, the unsolidified and transitory nature of 'reality' (Thomas, 2004c). The emphasis, for post-structuralists, is on interrogating the social groupings and discursive practices in the workplace within which the disabled identity emerges, and determining the power discourse has on the construction of subjectivities. For this reason, the two perspectives may be considered incongruent. Thomas (2004c) counters this often-cited notion of the dissimilarities between the social relational model and post-structuralism, noting that the model does not position binaries as 'real'; rather, binaries are considered social constructs. The definition of the model adopted in this study, as above-mentioned, underlines how disability occurs within the context of social interactions among individuals who have been 'socially constructed' as different from the norm, and individuals who meet the socialized criteria of normalcy. The model takes

disability and non-disability to be social constructs, enacted within social contexts such as organizations and families.

The Foucauldian perspective has also received criticism for seemingly constituting the 'subject' in the absence of 'agency'. Alcoff (1988), for instance, contends that the Foucauldian analysis renders feminism and the disability movement immaterial, given the lack of emphasis on issues of 'empowerment' which formed the crux of such movements. However, while Foucault, in his initial work seemed to construct the subject as lacking agency, he did note in subsequent work, as aforementioned, that there is no power without resistance (Foucault, 2000). The Foucauldian perspective, thus, allows for the resistance of power. Besides, the emphasis for post-structuralists is on deconstructing the positivistic claims of an objective reality and modernist suppositions of objectivity. The perspective moves from the social modellist 'fight against oppression' (Fawcett, 1999), to the discursive context within which social attitudes are shaped which result in the aforementioned oppression. As Yee (2013) puts it, even the experiences of impairment, the manner in which it is perceived, thought about, or referred to are constructed within discursive contexts shaped by power-knowledge interactions.

Summarily, the study posits that adopting the social relational model from a post-structuralist perspective is beneficial, both for extending the perspective, as disability is not only taken to occur within discourse, but also within the individual (internalized ableism) due to extant discursive relations, and extending the model by underscoring what informs social interactions. As Thomas (2004b) suggests, adopting the post-structuralist perspective for social relational analysis this way should aid in fully unleashing the potentials of the model. This is evidenced in Reeve's (2002) study where she adopts a post-structuralist perspective for theorizing the interrelatedness between internalized ableism, identity and impairment. Reeve posits that achieving such an integration between the investigations of internalized ableism and the interactional nature of disability contributes to post-structuralist considerations. Connell (2011) equally underscores the relatedness between the two, and points to how emphasis from both perspectives is on the social processes within which gender emerges. To position

disability as a product of the interactions between people socially constructed as 'normal' and those constructed as the 'others', is to query the essence of disability, and the notion of 'difference'. The post-structuralist stance aids in accomplishing this social relational inquiry, by highlighting how difference is socially constructed within discourse.

3.9 Conclusion

This chapter established the theoretical basis of the study. First the chapter considered the two major disability models, the medical and social models. It is vital to note that both models largely govern current social and legal considerations of disability in the UK, impacting on how BPD individuals are received in the society/workplace, and influencing the conceptualizations of BPD in disability and work research. Previous considerations of BPD, as with the majority of impairments, often adopt the medical model (Vickerstaff et al., 2012), with several pointing to the impact of BPD on employees' performance, and the incapacitating effects of the condition (Michalak et al., 2007; Rosa et al., 2010; Marwaha et al., 2013). The social model is increasingly being adopted in disability research, with several academics acknowledging the significant role structural barriers play in the disablement of employees with impairment (Roulstone et al., 2003; Newton et al., 2007; Shankar et al., 2011; Bertilsson et al., 2013; Harpur, 2014). The majority of these recent studies yet tend to focus on the disablement that occurs at work, rather than on how restrictions are socially created. Hence, studies that broaden the social analysis of BPD beyond the emphasis on structural barriers are limited in disability and work literature (Williams and Mavin, 2012). As noted in the chapter, there is also little consensus amongst social modellers on the intricacies of the restrictive structures often underscored in the model, or how restrictions are created. Besides, while the social model provides context for confronting the disadvantages individuals with impairment experience in the society, and challenging the prevailing discourse on disability (Radermacher, 2006), the model is largely associated with physical impairments (Simpson et al., 2013). The subjective experiences of BPD employees in the workplace, and the particular means through

which BPD becomes ‘disability’ due to the context of work, therefore, remains largely under-researched within both the medical and social models.

Hence, while the current study acknowledges the significance of the social modellists’ perspective in examining the experiences of impairment in the workplace, the study argues for an expansion from the focus on the restrictions faced by BPD individuals, to include some consideration of the specific means through which barriers are constructed in the context of work. For this reason, the study adopts the social relational model of disability. This extends the reasons for disablement in the workplace and labour market from individualistic forms of enquiry to social rationalizations of BPD, and to the discursively constructed nature of work. Emphasis is on how work contexts are socially constructed to delineate difference, and how delineations are sustained within social interactions, with the resultant effect on subjectivity. From a theoretical perspective, BPD is taken to be a linguistic product, and is theorized in the study by analyzing the discursive constructions and experiences of BPD in the workplace; conceptualizing the inter-relatedness between such interpretations and the (normative) work contexts within which they occur; and finally, conceptualizing the connotations BPD employees make of their experiences of BPD in the workplace; the overall aim being to develop knowledge of how BPD exists as ‘difference’ due to the discursive constructions of substandard existences around influences of power. The study is, therefore, situated within the context of theoretical attempts for understanding the impact of discursive definitions of ‘difference’ on BPD employee’s experiences, and on the sense of self.

This forms the basis of the study’s contribution to the understanding of the experiences of BPD in the workplace. With the theoretical considerations for the study complete, attention turns to the research design and methodology in the next chapter. Essentially, BPD employees are taken to be the creators of the knowledge which will result in theoretical insight in the study (Williams and Mavin, 2015). The next chapter examines the research methods that aid in achieving such analysis.

CHAPTER 4 Research methodology and methods

4.1 Introduction

As noted in the previous chapter, this study adopts an alternative approach to interpreting BPD in the workplace, the aim being to shift attention from individualistic forms of enquiry to social rationalizations of BPD, and the discursively constructed nature of work. This chapter examines the methodological approach adopted in order to achieve these objectives. The chapter presents the methods adopted in the study; and delineates some form of structure, relating research objectives to methodology. For this reason, the chapter is structured as follows. The first section reiterates the study's research objectives, while subsequent sections examine the research philosophy, methodology, methods, and the analytical procedures employed. Finally, the chapter concludes with a discussion of the ethical implications of the study, and a depiction of the specific correlations between the research methodology and the aims/objectives.

4.2 Research aims and objectives

The methodology adopted is targeted at achieving the overriding objective of the study, which is, to contribute to an understanding how the construct of work affects the lived experiences of BPD employees. The research paradigm reflects this objective. Specific research objectives include:

1. Providing a longitudinal examination of the full range of BPD employees' experiences of work, including securing and maintaining employment, as well as returning to work after sick leave/career interruption.
2. Determining the degree to which the nature of work may be considered ableist/normative.
3. Exploring the extent to which ableist physical/social aspects of employment affect BPD employees' experiences of work.
4. Investigating the extent to which discursive practices in the workplace shape BPD employees' interpretations and experiences of work.
5. Relating BPD employees' experiences of work to developing the social relational model of disability.

The next section examines possible philosophical standpoints for achieving the research objectives, from a methodological perspective, with particular emphasis on the standpoint most suited to the study.

4.3 Research philosophy

There are two key theoretical positions, with several categories between (Holden and Lynch, 2004). As illustrated in Table 4.1 below, on the one hand, there is the positivistic (objectivist) stance, and on the other, constructionist/phenomenology (subjectivism). Epistemological and ontological assumptions vary between the two.


	Subjectivist Approaches to Social Science				Objectivist Approaches to Social Science	
						
Core Ontological Assumptions	reality as a projection of human imagination	reality as a social con- struction	reality as a realm of symbolic discourse	reality as a contextual field of information	reality as a concrete process	reality as a concrete structure
Assumptions About Human Nature	man as pure spirit, con- sciousness, being	man as a social con- structor; the symbol creator	man as an actor; the symbol user	man as an information processor	man as an adaptor	man as a responder
Basic Epistemological Stance	to obtain phenomenol- ogical insight, revelation	to understand how social reality is created	to understand patterns of symbolic discourse	to map contexts	to study systems, process, change	to construct a positivistic science
Some Favored Metaphors	transcendental	language game, accom- plishment, text	theater, culture	cybernetic	organism	machine
Research Methods	exploration of pure subjec- tivity	hermeneutics	symbolic analysis	contextual analysis of Gestalten	historical analysis	lab experi- ments, surveys

Table 4.1: Continuum of six major philosophical perspectives (Adapted from Morgan and Smircich, 1980)

At one end of the continuum, positivists suggest that there is an objective reality, and consider reality to be constant, evident or measurable (Creswell, 2003). Researchers from this perspective adopt scientific techniques in their search for an absolute reality. At the other end of the continuum, subjectivists posit that reality is subjective. Humans do not simply respond to the social world; rather, they take an active part in its

construction (Bryman and Bell, 2007). For subjective researchers, the objective perspectives of the world and research are inadequate, and unsuitable for researching organizations (Morgan and Smircich, 1980). Several organizational and disability-related studies have been conducted from both perspectives. The positivist perspective, with assumptions of an objective reality governed by indisputable natural laws (Holden and Lynch, 2004) is representative of the medical model of disability. This is evidenced in the inclination of medical modellers to reduce social constructs to biology, due to the emphasis on measuring that which is 'reality' (Radermacher, 2006). On the other end are studies conducted from the subjectivist perspective, with emphasis on the disabling effects of the environment (Oliver, 1992; Barnes and Mercer, 2005b). Both ends of the continuum relate to the debate highlighted in literature on the differences between disability and impairment, and the question of either focusing research on individual features or (disabling) environmental features (Soder, 2009). While positivist researchers emphasize the individualized approach to disability studies, other academics (such as Oliver, 1990b; Davis, 1995; Barnes, 2012b) argue otherwise.

Positivism is often adopted in the study of natural sciences, while the social sciences are more inclined towards subjectivism (Saunders et al., 2012). Subjectivists accept that humans interpret their experiences subjectively, and such interpretations impact on individual outlooks and behaviour (Krauss, 2005). In essence, life experiences are interpreted in diverse ways, as a function of the discursive contexts within which they occur. Subjectivists aim to untangle such interpretations, underscoring how they have been constructed (Easterby-Smith et al., 2012). These notions of subjectivity are implied in the aims of the current study. As demonstrated in the research question: *How do BPD employees make sense of their position in the workplace?* the study acknowledges that numerous realities exist. Experiences and opinions vary between individuals (in this case, BPD employees), and may vary across different contexts over time. Hence, the study is on the subjectivist end of the philosophical continuum.

Subjectivism questions the very nature of that which is considered to be reality, thus, enabling qualitative researchers the freedom to extend analysis past individualized perspectives of disability (Eisenhardt, 1989). When applied to this study, the

perspective underlines that the conceptions of normalcy do not develop from ‘nothing’ (Ballard, 1997); rather, they produce and are produced in response to the discursive framework upon which work is structured. From this perspective, if knowledge is to be developed, the very means through which ‘reality’ is constructed needs to be investigated. Several theoretical components exist at the subjectivist end of the continuum, such as interpretivism and post-structuralism (Jorgensen and Phillips, 2002; Cassell and Symon, 2004), the common ground being the focus on subjective epistemologies and realities. It is the norm in disability studies for research objectives to determine a study’s philosophical stance (Saunders et al., 2012). The interpretive approach, for instance, was employed by O’Brien (2001) in order to comprehend how a participant who was termed as having a learning condition was able to learn effectively. O’Brien (2001) applied the symbolic interactionism approach, and was able to illustrate that the constructions of learning ability differ from one context to the other. Whitburn (2014), on the other hand, adopted a post-structuralist perspective for examining how the discourse in schools influenced disabled students, the aim being to counter the traditions through which certain students were being marginalized. Other philosophies have been adopted in diverse studies to suit particular research objectives.

Given the current study’s objective: *Providing a longitudinal examination of the full range of BPD employees’ experiences of work, including securing and maintaining employment, as well as returning to work after sick leave/career interruption*; the study adopts a philosophical stance that accounts for the multiple views of individuals who live and work with BPD, as evidenced in the use of language. Furthermore, the objective: *Investigating the extent to which discursive practices in the workplace shape BPD employees’ interpretations and experiences of work*; necessitates the form of analysis which highlights social interactions, discursive processes, and the context of work in the production of realities. Hence, the study adopts a post-structuralist-oriented methodological stance. As noted in the previous chapter, the post-structuralist perspective facilitates the realization of the research objectives due to emphasis on the constructive role of discourse, and on how individuals make sense of, or experience BPD. Studies from the perspective depict how a phenomenon, hitherto considered the ‘truth’, may essentially be a social product of language.

A post-structuralist methodology is reflective of the ontological and epistemological stance adopted in the study on the subjectivity of meaning. The epistemology of the standpoint challenges the constructions of reality as 'normal', and highlights the social realities of BPD employees (Williams, 2011). Reality is taken to be what humans make of it, constructed through language and discourse. Having adopted a post-structuralist perspective, the study acknowledges that individual interpretations are the result of discursive influences, with subjectivities constantly informed via extant discourse (Wright, 2003). An employee with BPD will, for instance, come to interpret their experiences as a worker, and construct the nature of work, via the framework of discourse available both within and outwith the workplace. Disability is, thus, a subjective experience, known as reality by individuals in diverse ways, due to the differential influences of language and discourse. Adopting this perspective facilitates the development of theoretical explanations for how and why 'otherness', or in this case disability, exists relative to the discursive constructs of 'substandard' realities, around influences of power in the workplace.

This section locates the study at the constructionist end of the continuum, with particular emphasis on the role of discourse and power in the constructions of work experiences, and of realities. It is expected that adopting a post-structuralist standpoint will facilitate an analysis of the external influences of discourse, and aid in developing theoretical interpretations of how disability is constructed in relation to the normative context of work (Soder, 2009). Having set some groundwork for the study's philosophical stance, attention turns to the research methodology employed in the next section. The research philosophy dictates the research methodology; hence, the methodology adopted reflects the philosophical stance of the study.

4.4 Research methodology

There are two major methodologies employed in research; these are the quantitative and qualitative methodologies (Saunders et al., 2012). Quantitative methodologies employ standard techniques for data collection and analysis (Creswell, 2003). They address 'what', 'where' and 'when' enquiries. The positivistic approach is highly related to the quantitative methodology, particularly when employed with pre-set and standardized

means for collecting data. Conversely, the qualitative methodology relates to social constructionism (Denzin and Lincoln, 2000), with emphasis on understanding subjectivity. Qualitative researchers position reality as a social construct, and interpret phenomena on the basis of subjective narratives (Denzin and Lincoln, 2000). Social modellists, such as Oliver (1992), argue against the use of quantitative techniques for disability studies, noting that quantitative techniques essentially ‘disregard’ the individuals being researched (Denzin and Lincoln, 2000). This contradicts the essence of post-structuralist research, which often takes the form of giving a voice to individuals, particularly those who have been under-represented in the analysis of the workplace (Gabriel, 2008; Curry et al., 2009). The nature of this study lends itself to the qualitative approach (Strauss and Corbin, 1998), and would be incongruous with numerical analysis. It is, therefore, practical for the study’s methodology to be qualitative. The collection of rich narratives on the interpretations of BPD in the workplace should facilitate an in-depth investigation of the influence of discursive practices on BPD employees’ experiences of work (Bryman, 2012).

The research methods adopted in the study are inherently dependent on underlying assumptions of the qualitative methodology outlined in the section above. The next section examines these methods.

4.5 Research methods

Post-structuralists carry out analysis on the use of language in the construction of subjectivities via several means; some of these include narratives, personal experiences, life histories, or the exploration of emotions and feelings (Gabriel, 2008). These forms of data are obtained via interviews. Hence, interviews are employed for obtaining BPD employees’ stories in this study.

4.5.1 Interviews

There are two basic forms of interviews, as illustrated in Figure 4.1 below. First, there are standardized forms of interviews, with highly structured formats, where consistent questions are used for each participant. Then, there are non-standardized interviews,

where discussions are unstructured and relaxed (Creswell, 2003). There are several means for carrying out interviews, as shown below:



Figure 4.1: Forms of interviews (Saunders et al. 2009, p.321)

Non-standardized interviews are of two types: semi-structured and unstructured interviews. Unstructured interviews are relaxed, and can be used for conducting comprehensive research on specific phenomena (Bryman and Bell, 2007). Similarly, semi-structured interviews are largely ‘non-standard’, they may have a layout, but are quite flexible. Both unstructured and semi-structured interviews are also referred to as qualitative interviews (King, 2004). Standardized interviews, on the other hand, are more structured and consistent. Such interviews are often used for collecting measurable data, and are referred to as quantitative interviews (Bryman and Bell, 2007). The two types of interviews are suited for various forms of research. Structured interviews are typically used for gathering quantitative data. This could, for instance, be data from surveys. Conversely, unstructured and semi-structured interviews are typically used for gathering qualitative data, such as data from case studies (Saunders et al., 2009). Qualitative interviews are, for this reason, suited to studies that lay emphasis on the use of language in narratives and stories (Easterby-Smith et al., 2012). It is valuable where emphasis is on understanding why participants feel or react to phenomena in certain ways (Robson, 2002). It is, therefore, practical for the current study to employ semi-structured interviews.

4.5.1.1 Semi-structured interviews

Semi-structured interviews were particularly useful for the comprehensive exploration of the language used by participants to express personal views and experiences, and aided in generating narrative interpretations of the experiences of BPD at work (Easterby-Smith et al., 2012). As evidenced in the research question: *How do BPD employees make sense of their position in the workplace?*; this study is deeply entrenched in personal meaning, and in participants' perceptions of that which is under study (BPD). Participants are regarded as playing two roles, the role of the constructed and that of the constructor (Morgan, 2010). In essence, participants' interpretations are the focus of the study. Hence, while there was an order to the questions used during the interviews conducted in this study, the participants were allowed free reign for the major part. There were *a priori* questions to suit the major themes of the study, offering adequate opportunity to explore and secure comprehensive accounts of the experiences of BPD (Bryman, 2012). For instance, participants were asked to describe their experiences of work before and after diagnosis, with emphasis on the changes that occurred after they received the diagnosis of BPD. While there were follow-up questions, such as 'why do you think this happened?', they were allowed free reign when narrating such experiences. [Please see Appendix 1 for a summary of the interview questions and the research objective/question addressed]. As Oliver (1990c) observes, the redefinition of experiences via language is intricately connected to the process of naming or describing personal experiences, and studies that allow such redefinitions shift attention from individualistic to social rationalizations of disability. This form of data collection, therefore, aids in shifting the research focus from positivistic attempts to a qualitative approach.

Three sets of interviews were conducted over the period of a year with eight participants. Each participant received an information sheet, and consent was obtained either via signature or verbally on phone/Skype. [Please see Appendix 2 and 3 respectively for a copy of the information and consent sheet]. The repeat interviews introduced longitudinality to the study, which adds value to the study given that the experiences of participants could vary over time due to the episodic nature of BPD. The

longitudinal approach also relates to the position taken in the study on the transitory nature of identity, and the ever-changing nature of work. The study enjoyed other benefits of having multiple interviews with each participant, such as the opportunity to further probe answers, and crosscheck emerging codes/themes with participants during subsequent interviews (Sutton, 2012).

People often discuss their connotations of work or life in general as some form of narrative (Czarniawska, 2008). Hence, a life history technique was adopted for the initial interviews. The life history approach involves the application of narrative techniques to aid participants in recalling, recounting and reviewing their experiences (Nind, 2008). This entails practical means for eliciting narratives by, for instance, encouraging persistent reflexivity on past experiences. The approach is beneficial for putting participants' interpretations into context, and discovering the meaning attached to interpretations (Saunders et al., 2009). Incorporating personal stories is also valuable for understanding the experiences of socially imposed identities such as disability (Stephens and Breheny, 2013). In examining how stories are told, researchers are able to analyse the influence of contextual features, or in this case, discursive features on the personal interpretations of disability. Employing the life histories approach in a semi-structured manner supports the investigation of the subjective experiences of participants, as evidenced in the constructions of experiences of BPD at work (Marshall and Rossman, 2006).

4.5.2 Recruiting participants

Participants are recruited in research through two major sampling techniques namely probability and non-probability techniques (Bryman, 2012). For the non-probability or purposive technique, the prospect of being nominated is unknown (Creswell, 2003). Conversely, with the probability techniques, the prospect of being nominated is known and equivalent for everybody (Saunders et al., 2009). Probability sampling is typically used in quantitative studies (Curry et al., 2009). Purposive sampling, on the other hand, is employed for selecting participants who have directly experienced the phenomena being studied. The purposive technique is often employed in qualitative research due to small sampling sizes (Curry et al., 2009). Given this study is neither positivistic nor

quantitative; the usual rules of quantitative sampling did not apply (Saunders et al., 2012). However, in order to achieve the research objectives, an in-depth analysis of participants' stories had to be conducted on a small-scale basis. Participants were, therefore, purposively recruited.

Traditionally, qualitative studies tend to adopt purposive participant recruitment with a reduced number of participants. This is more so where emphasis is on language and narratives (as is the case with this study), as such research could yield large data sets. McCracken (1988) suggests having eight interviews, Ellis and Bochner (2000) posit between five and six, while for Eisenhardt (1989), between four and ten interviews should suit qualitative narrative studies. Hissong (2005) recruited four women for narrative research, while Khoddami (2010) recruited eight. Goldberg (2007) adopted a narrative social constructionist approach for examining the lived experiences of BPD. The study had six participants. Williams (2011) similarly examined the career boundaries evidenced in disabled academics' narratives. The study investigated eight participants' narrative accounts. Life histories, in particular, entail a small number of participants due to the fine-grained analysis involved (Baker and Edwards, 2012). Given the perspective adopted in this study, in addition to the narrative approach employed for analysing data, it is expected that a range of eight to ten participants would be adequate for addressing the research objectives. Specifically, this is aimed at generating sufficient data to address the set research questions.

The ideal participants are individuals with a diagnosis of BPD who have worked in the past, or currently work. It is expected that participants will come from diverse work backgrounds, enabling the investigation of variations in meaning within the contextual features of participants' workplaces. The particular forms of participant recruitment adopted in the study are the self-selection and snowballing techniques. Combining both techniques will help achieve some element of purposiveness. For the self-selecting participants, the study will be publicized via appropriate social platforms, encouraging BPD individuals to indicate their interest to take part. The snowballing technique will subsequently be employed. The snowballing technique is particularly suited to the study due to the sensitive nature of the phenomena being studied, and the probability that not

all employees with BPD would have disclosed at work. As Browne (2005) notes, the snowballing technique is most suited to studies where participants belong to ‘groups’ that are under-researched or difficult to access, and where the subject-area is regarded as sensitive. Both techniques would usually have no pre-determined delineations, and are inductive. Having adopted these methods, eight participants were successfully recruited for the study. Participants’ details are outlined in the next sub-section.

4.5.2.1 Participants’ details

The study was promoted on social media, and through direct contact with a range of self-advocacy BPD groups in the UK between November 2014 and June 2015. Seven of the eight participants recruited were self-selected, which is indicative of the readiness of participants to discuss their experiences. One participant was referred by another participant. Participants’ details are summarized in Table 4.3 below:

	Interview 1	Interview 2	Interview 3	Age	Gender	Educational qualifications	Marital Status	Job role	Full/Part -time
Participant A	22/12/14	03/04/15	09/10/15	48	F	Postgraduate	M	MH support	Part- time
Participant B	22/01/15	08/05/15	01/10/15	66	M	Postgraduate	M	Teacher/ MH support	Full- time
Participant C	31/03/15	17/08/15	16/03/16	49	F	Postgraduate	M	Self- employed/ Student	Part- time
Participant D	21/04/15	16/07/15	18/11/15	38	M	Postgraduate	M	Local Authority	Full- time
Participant E	15/05/15	25/08/15	19/11/15	41	F	Postgraduate	S	Counsellor	Part- time
Participant F	23/06/15	31/10/15	06/01/16	28	M	Postgraduate	S	Property agent	Part- time
Participant G	14/07/15	19/09/15	16/02/16	34	F	Undisclosed	S	Research manager	Part- time
Participant H	24/07/15	06/11/15	19/12/15	35	F	Undisclosed	M	IT project manager	Full- time

Table 4.3: Participants’ details

The majority of the interviews were conducted on Skype/phone between December 2014 and March 2016; some were conducted in person at various locations. Each participant was interviewed three times, at varying intervals over the period of a year. The first interviews adopted a life history approach, and focused on the subjective experiences of participants, as evidenced in their construction of the experiences of

being diagnosed and working with BPD (Marshall and Rossman, 2006). The second and third interviews followed on from the discussion of participants' personal experiences in the first interview, and examined the experiences of work. Each interview started with a discussion of participants' rights. This was followed by questions to invite participants' narratives. The interviews lasted between 60 to 120 minutes. According to Riessman (2000), transcription is vital to narrative analysis, as during the process, pertinent narratives may begin to emerge. At this stage, there is the opportunity to detect stories that interlink or intersect, and note where stories deviate from each other (Clandinin and Connelly, 2000). The interviews were, therefore, transcribed verbatim by the researcher. Participants' narratives were subsequently presented in two chapters (Chapters 5 and 6).

This section examined the research methods adopted in the current study, in relation to how data was collected, and how participants were recruited. The next section examines the means through which the data collected was analyzed to induce theoretical insight into the experiences of BPD in the workplace.

4.6 Data analysis

There are two forms of research reasoning, namely induction and deduction (Saunders et al., 2012). The inductive approach entails the transition from particular observations to wide generalizations. Conversely, the deductive approach entails transition from a set of general assumptions to a more specific conclusion (Ketokivi and Mantere, 2010). The form of analysis adopted in research is largely dependent on the research questions (Shaw, 2007). Where data is qualitative, emphasis is usually on what the data 'says' in response to specific research questions. Hence, given that the current research is qualitative; the research adopts an inductive analytical approach. Two major arguments back this decision. First, there is the argument that deductive techniques wherein *a priori* external positions are enforced on the conduct of the social phenomenon being studied are inadequate, particularly when the phenomenon being studied has subjective competences (Cassell and Symon, 2004).

Secondly, it is argued that in the place of the *a priori* nature of deductively tested notions, inductively grounded analysis of the social phenomenon being studied is better

suited to qualitative studies, due to the close relationship between data collection and theory building (Cassell and Symon, 2004). This way, knowledge emerges from the data collected, rather than being forced on it. The study, therefore, analyses data inductively. Several academics do recommend having some form of basis at the inception of a study. Easterby-Smith et al. (2012), for instance, note that research cannot take place without basic suppositions which guide the research process. Saunders et al. (2009) equally suggest that having some form of theoretical positioning when commencing research is valuable, as it aids in linking the study to an extant body of knowledge. The social relational model of disability acts as the basis for this study, and is the 'specific observation', from which theoretical developments will be made. It is, however, important to note that the model has no control over the research process itself.

There are several forms of inductive techniques for analysing data. According to Saunders et al. (2009), the major ones include narrative analysis, grounded theory, analytic induction, data display and analysis and discourse analysis. Saunders et al. (2009) describe each technique as follows: narrative analysis procedures are employed as means for exploring links and socially produced details in narratives, and would usually accompany methods such as story-telling, life histories and auto/biographies. For the grounded theory approach, detailed analytical processes are employed for generating theoretical explanations based on the significant themes that emerge from data. Analytic induction techniques are often adopted alongside the case study approach, and involve the exhaustive analysis of specific cases in order to determine the basis of precise phenomena. Miles and Huberman's (1994) data display and analysis technique enables researchers to compare components of data in order to ascertain the major themes and interactions occurring within data, while discourse analysis considers the constructive role of language in research. Considering that the current study pays particular attention to the language used in narrating life histories, and the influence of discourse on the construction of subjectivities, an analytic technique which involves the examination of both the nature and context of language will be apposite for the study. Hence, of the five inductive techniques proposed by Saunders et al., the narrative

approach seems most suited to the research objectives. This will be combined with Foucauldian analyses, as discussed below.

4.6.1 Narrative analysis

The study adopts the narrative approach for analysing data. Qualitative narratives, according to Gabriel (2008), are beneficial where under-represented individuals form a part of research. Such forms of analysis are particularly suited to research involving socially imposed identities such as disability (Stephens and Breheny, 2013). Adopting the narrative analytical technique enables the research focus on understanding how discourse (and the language used in interviews), both creates and replicates the social world (Saunders et al., 2009). The approach aids in considering all facets of workplace experiences, in terms of contextual, social and personal facets (Clandinnin and Connelly, 2000). It is via the use of narratives that individuals generally express their views/perceptions of phenomena, as determined by the discursive contexts around them. Hence, in narrating their experiences, participants will reveal something of the nature and context of their workplace (Stephens and Breheny, 2013). The contextual features of participants' experiences may underscore the variations in meaning.

Aside from underlining the context within which narratives occur, narrative analysis is also one of the major means through which the self can be explored. The narrative method acknowledges that people often develop a sense of self, which is presented to the society, via the means of narratives (Hiles and Cermák, 2008). The contents of narratives point to an individual's interpretation of self (Hunter, 2010), and offer insight into the particular social rules participants follow, for instance, with regards to how they should react or relate with others. This form of analysis is, therefore, particularly reflective of the philosophical standpoint adopted in this study on the constructed nature of reality, and the development of subjectivities within discursive influences. As Hiles and Cermák (2008) put it, the narrative approach is relatable to the post-structuralist perspective given the absence of the quest for 'one truth'. Post-structuralism and narrative techniques both differ from the narrow conceptions of science (Clandinin and Rosiek, 2007).

Several studies have adopted a combination of the post-structuralist perspective and narrative techniques. Dick (2013), for instance, employed a discursive method for exploring how particular events have come to be interpreted as sexist, with emphasis on how respondents developed an understanding within conversational processes. Freeman (2004) places the stories of respondents within contemporary accounts of art, laying emphasis on the invisible constructs and connotations that mould narratives. Hollway and Jefferson (2000) equally employed the narrative approach for mapping participants' interpretations of crime, drawing on linguistic means. Squire et al. (2008) consider the use of narratives in Foucauldian analysis, noting that both positions accept that several identities occur in the construction and interpretation of a narrative, which are shaped by discursive contexts. That is, people, while narrating their life experiences, both construct and are constructed by discourse. This suggests that the integration of narrative analysis and post-structuralism guarantees an investigation that depicts how discourse manifests in participants' narratives (Mik-Meyer, 2016). The two positions are, thus, integrated in the study to aid in developing an understanding of the subjective experience of BPD.

According to Riessman (1993), there is little or no unanimity on the techniques for carrying out narrative analysis. Diverse methods can be adopted, and there are several adoptions of the approach within different subject areas. This has resulted in varying means for employing narratives in qualitative studies (Kelly and Howie, 2007). Some studies employ life stories, while for others, narratives are simply taken as the stories obtained during interviews. Riessman (2005, 2008) suggests four general narrative techniques for analysing personal narratives, and notes that these can be used in conjunction with one another. The first is thematic analysis, wherein more attention is paid to the contents of the narrative, than to the language used. Secondly, narratives can be analysed using a structured approach, which involves paying attention, not just to content, but also to the causal connotations intrinsic to narratives. Emphasis is on the wider discursive context within which narratives are formed. Thirdly, the dialogic narrative approach entails the why, when and who of narratives. Emphasis is on the performativity in narratives. Finally, the visual approach involves the integration of representations and terms when exploring the visual constructions of social and

individual selves. The major difference between the four techniques lays in the conceptualizations of the construction/co-construction of the self and contextual influences.

The ontological and epistemological viewpoint of this study places it within the first and second techniques. Both techniques are well suited given the emphasis on personal stories, rather than collective ones (Fadyl and Payne, 2016). The structured narrative approach is particularly suited to the post-structuralist perspective, as it allows for the analysis of the discursive nature of the phenomena being studied (Gimenez, 2010). As Gimenez notes, where linguistic researchers adopt the narrative approach, emphasis is usually on the dynamic nature of narratives, rather than on the constructs of a sole 'reality'. The structured and thematic narrative approaches are, therefore, employed. The next section considers the second analytical method adopted in the study, the Foucauldian analytical technique.

4.6.2 Foucauldian analysis

Foucauldian analysis is employed in the study for examining the subjective interpretations of BPD, and the role of power in differentiating ability from disability. The Foucauldian themes of subjectivity and power are applied for exploring how the psycho-emotional dimension of disability is produced and sustained within the workplace (Reeve, 2002). The study also draws on the analysis of internalized ableism for exploring how the sense of self may vary from one discursive context to another. Analysis of 'text' from this standpoint allows for the identification of discursive influences in the construction of particular subjectivities (Cassell and Symon, 2004). A major supposition is that as participants talk and construct their experiences via language, they inherently act in relation to themselves, and to others, making choices – choices which are restricted to an available range of meaning-making tools (Wright, 2003). As such, Foucauldian analysis could reveal the means through which employees become constructed and subjective to the label of BPD. The results obtained from such analysis should offer new analytical insights into the experiences of BPD in the workplace, and contribute positively to both theory and research in BPD/disability studies.

4.6.2.1 Presentation of findings

The analytical process of the study was in two stages. The first involved transcribing and coding the data collected. Transcripts were coded and similarities in language use were noted, as these may be indicative of discursive influences. The researcher also underscored the developing narrative links. The second stage entailed exploring the specific discursive processes that impacted on participants' narratives, and locating these within the wider disability discourse. The Foucauldian analytical perspective of power was employed here for examining the invisible effects of power, and exploring how subject positions are produced via discourse. The analysis during this stage aided in highlighting the manner in which participants assumed specific 'identities' on the basis of available discourse. More importantly, both stages of the analysis allowed for an exploration of the interactions between the construction of work and the experiences of BPD in the workplace, as expressed and constructed in participants' narratives.

Participants' narratives are presented in two chapters. The first chapter presents the first stage of the analysis and adopts the thematic narrative approach. The chapter develops an understanding of the nature of work, and its impact on the lived experiences of BPD, the aim being to underscore particular norms which have been integrated into the way of life, and are considered normal. This analysis essentially attends to the social relational model, as it highlights how restrictions are produced and sustained within social interactions, and due to social norms. The structured narrative approach is adopted in the second analysis chapter, and attends to the second facet of the social relational model, wherein emphasis is on the psycho-emotional impact of discourse on BPD individuals. The chapter investigates the discursive constructions inherent in participants' narratives, and the development of subjectivities within such discourse. Two participants' narratives are considered in-depth in the chapter. The two participants were selected, of the eight participants, for several reasons which are discussed in Chapter six. Essentially, the two participants' stories are considered largely different from each other, seemingly representative of the two ends on a 'spectrum' of BPD experiences. Both participants were also considerably open during the interviews, and gave rich accounts of their experiences prior to, during, and after diagnosis. The

analysis in the structured narrative chapter follows the pattern/tradition of the techniques adopted in studies such as Stephens and Breheny (2013), Mancini and Rogers (2007), and Tucker (2009). It is vital to note that several participants requested for anonymity regarding the organization they work with. This information is, thus, excluded from the analysis.

This section examined the analytical procedures of the study. The consideration of data collection techniques and analytical procedures will, however, be incomplete without adequate consideration of ethics. The next section, therefore, examines the ethical considerations of the study.

4.7 Ethical considerations

Ethical considerations are a vital facet of qualitative research (Robson, 2002), and have significant implications for the entire research process (Bryman and Bell, 2007). Ethics can be regarded from two major perspectives namely responsibilities and risks (Saunders et al., 2009). Responsibilities are the duty of the researcher; while risks are possibilities for both the researcher and the researched. In terms of responsibilities, researchers have the responsibility to mitigate any risks which may come to participants (Easterby-Smith et al., 2012). These could be regarding either mental or physical risks, pertaining, for instance, to factors such as maintaining confidentiality or discussing sensitive issues. Such considerations played a major role in the current study, particularly due to the sensitive nature of the phenomenon under study. As Nind (2008) notes, there is the particular need for ethical considerations when conducting research related to disability, due to the sensitive nature of narrated experiences. Furthermore, disability studies have largely been critiqued for having the tendency to objectify individuals with impairment without contributing to an improved understanding of the social exclusion disabled individuals experience (Foster and Fosh, 2010). According to Nind (2008), it is unethical to disregard disabled individuals in a study where disability is the focus, and where insights could be obtained from their experiences of work which may facilitate improved working conditions. These arguments have resulted in an increasing acknowledgement of the need for facets of sensitivity in disability studies.

The current study, by paying specific attention to the experiences of BPD in the workplace, and by including BPD employees as participants and possible recipients of the benefits of the study, adopts a vital perspective. Involving disabled individuals in a study which is beneficial for the experiences of disability in the workplace indicates conformity with the basic ethics of research. In addition, the study took steps to ensure that the research design does not subject participants to any form of disadvantage. Prior to the interviews, measures were put in place to ensure that the participants will not experience any disadvantages as a result of the research. For instance, in case participants became distressed during their narratives, or showed signs of a manic/depressive state, the researcher made provisions for ensuring that they are referred to adequate support systems, such as Breathing Space or Clear Mind. Essentially, the study adheres to Diener and Crandall's (1978) ethical framework, by ascertaining that:

- There is no harm to participants;
- Participants offer an informed consent to take part in the research;
- Participants' privacy is not invaded/violated in any way; and
- Participants are not deceived about any area of the research.

Adhering to these practices helped guard against harm coming to the participants of the study. There were also possible risks in the study for the researcher, such as the emotional impact of co-constructing participants' experiences. Such experiences could result in possible risks, in terms of, for instance, psychological discomfort or distress. A central facet of such risks in the current research is the relationship between participants and the researcher (Nind, 2008). Walmsley (2004) recommends proper negotiations before the research commences between both parties on the nature of interactions. For the current study, such risks were minimized as much as possible. The researcher is a certified mental health first aider, and knows how to practice good self-care. Provisions were also made for the researcher to debrief with supervisors after interviews, where necessary. This aided in maintaining some space between the study and the self. The position adopted by the researcher is related to the ethical considerations of the study, and is discussed in the next sub-section.

4.7.1 Position of the researcher

This section positions the researcher within the study in relation to the research participants. Narrative interview processes are often taken to be a co-construction (Hall and Powell, 2011). There were perhaps a few constraints to such co-constructions of the experiences of ‘othering’ with participants, given the researcher for the current study is non-disabled. It is, of course, important to note that, as Barnes (1992) suggests, academics do not need to have an impairment in order to carry out disability research. They, however, need to leave their prior capabilities and understanding of the subject area behind, in order to prioritize that of the disabled participants. For this reason, the researcher largely adopts an ‘unknowing’ position during the process of the data collection. In essence, having had no experiences of BPD, the researcher approached the interviews as the ‘unknower’, with participants positioned as the experts on the subject under investigation. Their stories guided the analytical process, although necessarily shaped by the researcher’s subjective positioning.

The data analysis process does have connotations for the power relations in the research, particularly with regards to the power the researcher holds as the analyst of participants’ narratives. As Verno (1997) notes, the manner in which research is carried out often has inferences for the distribution of power. For the purpose of this study, the research findings were constructed by the researcher; they, therefore, represent the researcher’s account of participants’ realities. This may be critiqued by scholars in Disability Studies, particularly social modellists, who argue for emancipatory research. Such academics contend that the power in research should be moved from the researcher to the participants of the research (Verno, 1997), with participants involved within each step and having control of the process. This probably would have proven difficult given that participants may not be aware of the theoretical positioning of this study. In such a situation, it may be counteractive to leave control with participants. Besides, while the adoption of an emancipatory approach may have been a valuable process, it would have proven impracticable in this research given the time frame of the study.

More importantly, the research does not claim to be emancipatory, and is not based on the social model. Rather, emphasis is on understanding the ‘disadvantages’ that occur in

the workplace due to the construction of work around the notion of the ‘ideal’ employee. Hence, the degree of participation adopted in the study is deemed suitable for achieving the set aims and objectives. The researcher carried the participants along where possible by reviewing emerging themes with them during the second and third interviews. The research purpose and design were also communicated to participants via an information sheet. They were given ample information regarding the study, which enabled them to make informed decisions regarding their participation. The results will also be forwarded to them at the final conclusion of the study. The ‘power’ in this study was, therefore, not totally separate from participants, as may often be expected in research conducted outside of an emancipatory position. The research findings were, nonetheless, constructed by the researcher. Having addressed the ethical concerns and the researcher’s position, the next section considers the possible limitations of the methods adopted in the study.

4.8 Limitations

The narrative approach is often critiqued as possibly resulting in personal reconstructions rather than actual lived experiences (Clandinin and Connelly, 2000). According to Hall and Powell (2011), some facets of narratives may not necessarily be precise given the passage of time, possible gaps in recollection, or the inclination to create and present a particular version of self to an intended audience, that is, the interviewer. This occurred, to some degree, in this study. Participants were found to, at times, contradict themselves over the course of the three interviews. An example is where one participant initially noted that they had not experienced any form of discrimination at work, but discussed in subsequent interviews how they had resumed work after sick leave, and were relieved of a managerial post, an experience that can be interpreted as a form of discrimination. Magnusson and Marecek (2015) suggest that such incongruities are bound to occur, and it is almost the norm for participants to contradict themselves to some degree during interviews, or have some inconsistencies in their narratives. This is more so given that the interviews in this study were conducted over the period of several months. Contradictions do not discredit participants’ narratives, rather, they may be indicative of the process through which

participants attempt to interpret and understand past experiences. As Corbin and Morse (2003) put it, in the process of recalling stories and alternating between the past and the present, contradictions may naturally occur.

In addition, the approach adopted in the study, and the number of participants connotes that the findings will not be generalized, as narrative techniques are often non-generalizable (Saunders et al., 2012). The study, however, does not aim to generalize or make assertions based on the data collected. The research investigates a fraction of prevalent discursive practices within and outwith the workplace, and does not claim to have exhausted the study of discourse in 'BPD and work' studies. Rather, the approach is aimed at developing an in-depth understanding of how participants interpret and narrate experiences of work. Emphasis is on employing the richness of the data obtained from interviews for connecting participants' accounts of BPD with the wider aspects of workplace discursive structures. The study underscores an under-researched area of analysis in BPD studies, by highlighting the particular mechanisms through which people may be 'othered' in the workplace, and is thus, pertinent to disability literature.

4.9 Conclusion

This chapter examined the reasoning behind the research design adopted in the study, from a methodological and theoretical perspective. The chapter outlines how the adopted research processes aid in obtaining BPD employees' views and perceptions of work. The overriding objective of the study, as noted earlier, is to contribute to an understanding of how the construct of work affects the lived experiences of BPD employees. This objective positions the study in the field of qualitative analysis, due to emphasis on the stories of BPD individuals. The research, therefore, adopts the qualitative approach and analyses data inductively, using narrative and Foucauldian analysis. Adopting the selected approaches and techniques should offer the best opportunity for attaining the set aims and objectives. Figure 4.2 below presents a summary of the research processes employed in the study.

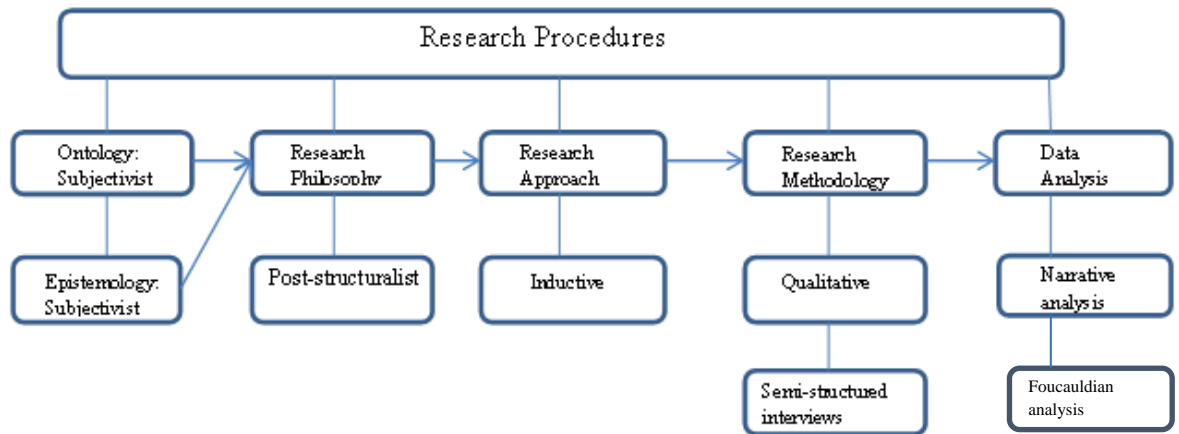


Figure 4.2: Research Procedures

Specific correlations between the research methodology and research aims/objectives are further clarified in Table 4.4 [Please see Appendix 4 for Table 4.4: Research methodology and aims/objectives]. Having examined the methodology adopted in the study in this chapter, the next chapter presents the findings of the data analysis.

CHAPTER 5 Constructions of Bipolar Disorder as disability within normative work contexts

5.1 Introduction

Having examined the relevant literature on BPD and the research methodology adopted for the study in the previous chapters, the next two chapters present analysis of the data collected. The current chapter presents the first part of the research findings, with emphasis on the structure of work, the aim being to investigate the degree to which work is accommodative of difference. Chapter six presents the second part of the research findings and underscores the inter-relatedness between participants' narratives and prevailing discourse both within and outwith the workplace. This chapter employs a thematic approach, due to the emphasis on emerging themes, and the added investigative benefits of comparing the construction of experiences in diverse narratives. Data is presented this way in order to highlight the intricacies of work organizations, and the relatedness between participants' experiences of the workplace. The chapter addresses four of the research questions outlined in the first chapter namely:

1. How do BPD employees experience securing and/or maintaining employment?
2. How do BPD employees experience work in settings intended for non-disabled employees?
3. What does the experience of BPD in the workplace indicate about the normative structure of work?
4. How can BPD employees' narratives contribute to an understanding of the social relational model?

The chapter is divided into two major sections. The first addresses the first research question by exploring participants' experiences of securing work, and experiences in the labour market. The second section examines the second part of the first research question, that is, participants' experiences of maintaining employment. Several themes are discussed in both sections, which address the other research questions. An overview of the themes noted in participants' narratives is given in Figure 5.1 [Please see Appendix 5 for Figure 5.1: Themes in participants' narratives]. The chapter concludes

with a discussion of the implications of participants' narratives, opening up room for further analysis of how narratives may be shaped by discourse in the following chapter. Participants' personal details have been anonymized in line with ethical criteria.

5.2 Securing work

This section examines participants' experiences when trying to secure work. The aim is to determine if the employment process and the way jobs are advertised disables/excludes individuals with BPD.

Since diagnosis, the majority of the participants of the study have experienced recruitment/selection. Participants have sought, at one point or the other, to either enter the labour market or change jobs. For several, these experiences were not notable as they believe their experiences to have been fair and equitable. Having had time to reflect, one participant did note during the second interview that they had experienced what they perceived to be discrimination due to a physical impairment:

I went [to interview] for a job that I was so overqualified for, it was ridiculous, and they told me that by that night, I will know if I had the job or not. They didn't phone me back, and by Wednesday [five days later], I was like forget it, I haven't got it, and that's okay. Then I got a phone call saying that I hadn't got the job, and I was okay with that. What did upset me was a few months later, I went back to do some work for them, and one of the guys on the panel said 'I was so upset to hear you turned the job down'. Basically, what we [later] managed to piece together is that the first person offered the job turned it down. It should have gone to me, but they offered it to the third person. And the person that made the phone calls told her colleagues that I turned it down. Now, to me, that is a level of discrimination that doesn't bear thinking about. (Participant C, Interview 2).

Participant C believes that the reluctance demonstrated by the recruiter was due to her physical impairment as a result of cerebral palsy. Where this is the case, such incidences may be indicative of how recruiters automatically relate impairment to incapability, and how recruitment methods may be predisposed towards ideal (non-disabled) candidates. For Participant C, such perceived experiences of discrimination were a recurring theme in the labour market. Having graduated, the participant proceeded to search for a job. This, however, proved to be a futile effort:

I went to university, which was fabulous. Four years complete, left ...I did pull my socks up in my final year, and got my 2:2. And I really thought the world was opened to me. Then, I got a shock, because there was no work for someone who was disabled, with all kinds of problems... (Participant C, Interview 1).

Participant C notes how she was eventually unable to secure a job, and had to start up a company. Again, the participant relates this to the physicality of her impairment, and the attitudinal barriers faced in the labour market. Aside from such experiences of overt discrimination, participants' narratives also highlight the less obvious means through which organizations discriminate during selection processes. One participant notes how selection procedures can inherently be unobjective:

People are very mis-conversed when it comes to interviewing, in all sorts of ways. They like to claim that they are not, but they are. I've watched my colleagues, and provided feedback on how they were reviewing interviewees. And I was saying, 'you say you don't ... [but] you want someone who is bright and capable, over someone who has a carbon copy job description, you're actually not favouring [people who are different]'. (Participant H, Interview 1).

Participant H's narrative is suggestive of the emphasis on the 'ideal' employee in contemporary work contexts. Applicants for a job position may, therefore, often be matched against peers, or the idealized worker, with organizations selecting candidates most fitting of an idealized notion of the perfect employee, one who is non-disabled. Such measures solidify patterns of exclusion for individuals who are unable to meet specific expectations. Aside from the selection process, recruitment practices may also inherently have discriminatory notions. For instance, the way jobs are advertised was found to, at times, inhibit participants from applying for job positions. This is evidenced in Participant A's narrative:

When I've been looking for jobs to apply for, I kind of go 'no I could maybe do this job, but I'm not going to be the sort of person they want to do it'. And I think it's partly to do with the way jobs are advertised, you know, dynamic, passionate, things like that. You're not always going to be passionate, it doesn't mean you might not be tenacious, or persevere, or things like that. But it's almost like they want super people, superman, superwoman you know? When I've been applying for jobs, when I've been quite down, it's really difficult to get past that. (Participant A, Interview 2).

There is evidence in other participants' narratives of similar experiences of self-selection, and the perception that they may not be what organizations are looking for. It

is, of course, natural for people to measure themselves against job requirements in job adverts, and while it could be that particular people would be dissuaded from applying for positions due to the terms used in adverts, it was found to apply to participants of the study particularly during depressive episodes. The terms used in adverts may, thus, be interpreted as inherent exclusionary techniques adopted by organizations during recruitment, which position the ideal candidate as one who is non-disabled. This is more so given that there will be periods where a person with BPD may not be 'passionate' or 'driven'. Recruitment and selection processes can result in discrimination through these means. Only few participants noted experiencing such barriers in the labour market. The majority have been able to secure jobs with little or no difficulties when seeking new job positions. Several participants, however, had to engage with job centres and support organizations while searching for jobs, and this was not always a positive experience. Participant C notes how, having searched for work for some time, she decided to go to a Job Centre:

I then ended up going to the Job Centre, which was another exercise in humiliation, and I was told to go and apply to disability organizations. (Participant C, Interview 2).

Participant C's narrative presents the notion that individuals with an impairment may be considered by job centres (and the labour market) as unfit for the 'standard' labour market, implied in the referral to organizations dedicated to disabled people. Such actions could promote notions of impairment as incapability, delineating the labour market on the basis of ability. Automatic assumptions of inability were also found in other participants' narratives. Another participant notes how she was advised to go on benefits after visiting the Job Centre:

Next thing, whoosh, depression hit again, and I ended up on Incapacity benefits, because I was signed off on job search... the Job Centre actually said no, you can go on Incapacity. (Participant A, Interview 2).

Similar to Participant C, this participant experienced differentiation in the labour market due to BPD. While other factors may have contributed to both participants' experiences with job centres, such as education and work history, the participants believe that the responses they received were a function of their impairment. Both narratives highlight

the tendency to equate impairment with disability or ‘inability’ in the labour market, in spite of the willingness to work. Job Centres may, for this reason, be interpreted as means for differentiating non-disabled candidates from disabled peers. Participant C puts it succinctly:

It almost seemed like in the days where if you were disabled, you worked ‘that lot’, irrespective of what your qualifications or knowledge base was. And I guess to a certain extent, it still is today. (Participant C, Interview 2).

As the participant notes, individuals with an impairment are often considered suited only to particular jobs, due to the assumptions of incapability; or excluded altogether from the labour market, due to the perception that they are unable to meet the social expectations of productivity. These narratives point to possible reasons for the lower employment rates experienced by individuals with BPD in the labour market.

This section examined participants lived experiences of recruitment and selection. As noted earlier, the analysis in the section deviates from the emphasis in previous studies on employment and labour market rates. Rather, emphasis is on examining the nuanced experiences of participants, and placing them within the context of the labour market. The section highlights possible discriminatory practices in recruitment/selection processes, which result in the individualization of BPD. Having examined participants’ experiences of securing work in this section, the remainder of the chapter explores participants’ experiences of maintaining work and returning to work after sick leave.

5.3 Maintaining work

This section investigates participants’ experiences of maintaining work, and addresses the first research question. The section achieves this by examining, first, participants’ experiences of disclosure in the labour market/workplace, and subsequently, experiences of workplace support and return-to-work (RTW) procedures after sick leave.

5.3.1 Disclosing Bipolar Disorder

This section explores participants’ experiences of disclosure while attempting to maintain work. As opposed to employees with physical impairment, participants had some degree of choice in deciding whether to be ‘disabled’ at work or not, and were

often faced with this choice. For some, disclosure at work was the preferred choice; while for others, the need to maintain a non-disabled self was a priority. The section examines, first, participants' experiences of disclosure, and then examines the experiences of non-disclosure, and the resultant emotional labour experienced by participants.

Six participants of the study have disclosed BPD at work at some point in their career. This was for varying reasons. For some, the decision to disclose was largely due to the need to be open about the condition. One participant, for instance, notes how it just felt right to disclose:

I told my first manager simply because... it felt right to tell her, and it felt good to tell her. (Participant A, Interview 2).

There were also participants who disclosed, reflexively, during a manic episode, and had little control over the decision to disclose. One participant describes this experience:

I don't think there's anybody who doesn't know. When I was diagnosed, I was manic, and I didn't have the ability to not tell people... and then every time my bosses changed, just as soon as they've come into the office, I've just said 'by the way you need to be aware that I'm bipolar, and I can behave strangely, and if you see this and this, then you need to send me to the doctor'. (Participant G, Interview 1).

For Participant G, the initial disclosure was less of a choice; the participant, however, did not express regret about disclosing the condition, and also conveyed the need to be open about having BPD. There is evidence in her narrative of how participants may disclose in order to preserve a competent identity at work. She discussed disclosing to new managers in what seems to be a pre-emptive move to retain a valued identity in the workplace, particularly where BPD might have affected her performance. This can be interpreted as means for managing impression, as it ensures that any possible 'issues' with her performance or behaviour is linked to BPD, rather than to her proficiency.

Regardless of participants' reasons for disclosing, one of the themes that emerged in participants' experiences is the somewhat visible nature of BPD symptoms. Participants believed that had they not disclosed, their behaviour during episodes would have

generated suspicion amongst colleagues. Participant G, for instance, notes that on disclosure, her boss was able to identify the symptoms of BPD in her behaviour:

When I was diagnosed, and my boss came up to see me at the house a couple of weeks when I went off sick, and I gave them all of these stuff that my mum had given me for bipolar, and I asked them to look at it, and see whether or not they thought that that was their experience of me, and they were just like, yeah, yeah, that's you. (Participant G, Interview 1).

Other participants had similar experiences. For the majority, there was often some previous knowledge from the recipients of disclosure. One participant describes the reaction from friends on the disclosure of the condition:

My friends were like 'yeah, we worked that one out ages ago, we were wondering when you were going to go to the doctor'. (Participant H, Interview 1).

Participants' narratives highlight how BPD episodes may present in perceptible behaviour in the workplace, thus rendering the condition somewhat visible. Such visibility may have implications for personal interpretations of the condition, particularly where participants seek to keep the condition a secret, as discussed further in the next section. This notwithstanding, participants experienced disclosure in different ways. For some, disclosure proved to be a positive experience. One participant narrates her experience, having disclosed during a sick leave:

I came back, and they were all extremely positive. I didn't experience any discrimination; everyone was just really pleased to see me return. I don't think people knowing about the diagnosis has affected my career. (Participant H, Interview 1).

Participant H experienced support from work upon disclosing BPD. This seemed to be a function of the value she brought, and the amount of time spent with the organization. She, for instance, adds:

I mean, they've seen me doing my job for two years with no problems. (Participant H, Interview 1).

The participant relates the positive response received to the consistency she has demonstrated since joining the organization. The positive response, nevertheless, proved beneficial for the participant, and she felt enabled due to the support received.

Participant G had narratives similar to Participant H's. She describes how colleagues were receptive after disclosure:

They were fab ...and everybody's been really ...I've never had a single person make me feel like I'm less of a person, because I've got bipolar. (Participant G, Interview 1).

Disclosure had positive effects for both participants, and resulted in positive work narratives. Building a constructive work identity seemed more achievable within such supportive work contexts. This is indicative of the vital role played by the workplace and organizational reactions in participants' general experiences of work. There were, however, participants for whom disclosure had adverse effects. Adverse responses occurred in different ways. For some, it resulted in exclusion, as found with Participant C:

It's really odd isn't it? It's so brutal I was so open about it to begin with, and people I thought would be understanding completely ran away. (Participant C, Interview 1).

For others, the organizational response was indicative of an immediate relegation to the role of 'incapable'. One participant notes how the information was received by the HR manager in his organization:

I met with my line manager and HR manager who deals with mental health at work. During this meeting, I was handed a document on BPD that I was expected to read... I found this laughable really, and a bit insulting. I was also told to ask for more help when under too much strain, I did and didn't get it, and to take time off work if need be. (Participant D, Interview 1).

The same participant notes in the second interview that the HR person said: '*next time, spend some time at home*'. The participant's narrative demonstrates a possible lack of understanding of the condition in his organization, and correlations between notions of incapability and BPD. The participant's organization seems to draw on the medicalized understanding of MHCs as unpredictable and tasking, hence, the paternalistic 'advice' to stay away from work during future episodes. Disclosure, in this case, seemed to reinforce an adverse subjective position for the participant, strengthening the perceptions of people with MHCs as less 'capable'. Participant D did resist such notions, as evidenced in his narrative:

I hadn't had a day off work for eight years, until last month [between first and second episodes]. I didn't really buy into this ...for me, rattling around a big empty house on my own would not help, as the extra energy and crying opportunities would make this a poor option. (Participant D, Interview 1).

Participant D notes the need to be at work in order to manage the condition, and resists the notions of incapability attached to BPD by his organization. This seemed to be a theme, with several participants noting the vital role played by work in the lived experiences of BPD:

I do find work quite very therapeutic, because if you can reach a level where you're in flow, you seem to disappear, so if you can really live in the present, all the voice stuff and nasty stuff just go, and now there's no anxiety about the future, there's no sadness about the past, you're very present, so work, to me, is the best drug. (Participant C, Interview 1).

Such participants consider work as vital to their experiences of BPD. Furthermore, it becomes evident that participants' experiences of disclosure are a function of organizational response. Where participants had adverse response, the resulting difficulties reverberated and affected other facets of work, thus impacting on participants' general experiences of work. Participant D, for instance, notes:

I don't think there's a very good understanding of it, of the condition, basically that works against the person that has the condition. It's effectively ruined, not ruined my career, I mean I haven't lost my job, but unfortunately, you know, the mantra is MH, talk about it ...it's really out there. In reality, it's 2015, and you will be better to keep these things to yourself if you want to get on. (Participant D, Interview 2).

Participant D's narrative is representative of the costs attached to disclosing BPD, as organizational/social response may not always be positive or supportive. He re-emphasizes the point in the narrative below:

I'm sure some people might even get sacked. One of the managers actually said that I was lucky I didn't get sacked! I thought this was quite unbelievable as I didn't actually do anything wrong. (Participant D, Interview 2).

Due to this possible stigma, the majority of the participants are not keen to disclose the condition at work.

Participants' narratives in this section highlight how MHCs may be constructed as some form of deviation from the norm in social discourse, and in the workplace. Even though

MHCs are increasingly being discussed, and there seems to be a growing acceptance in the UK, there is yet evidence of the stigma attached to the conditions. Several participants were found to experience stigma in the form of discrimination after disclosure. Having examined participants' experiences of disclosure in this section, the following sub-section considers the experiences of participants who did not disclose the condition at work.

5.3.2 Experiences of non-disclosure

While some participants disclosed, there were participants who have never disclosed their BPD at work, or have chosen at one time or the other not to disclose. Such participants chose to present a 'non-disabled' self at work. The decision not to disclose was for several reasons. There were participants who believed having BPD is a personal issue, and should be kept private. One participant, for instance, comments:

No one is aware; I've not let anyone know. I don't want to tell them my personal issues. (Participant F, Interview 1).

The participant felt that there was no need to disclose a personal issue at work, likening it to admitting to some form of weakness. He, therefore, kept the condition to himself, and hid any difficulties faced as a result. There were also participants who did not disclose at work due to the fear of stigma. Some participants made direct reference to this:

I didn't tell at work or anything; I was frightened of the stigma ...I thought that if I told them what my diagnosis was, they will think I was unfit for work. (Participant E, Interview 1).

Again, participants demonstrate trepidation of the stigma attached to MHCs. There was the fear that employers would perceive them as liabilities rather than assets. Related to this was the fear of what will change if their colleagues or prospective manager found out about the condition. Several believed that revealing the condition may result in being discredited at work:

I don't know what would happen, but some people will definitely view you differently, they will think you're disabled, they will treat you differently. (Participant F, Interview 1).

I would never reveal it during an interview, because then they're thinking 'oh what if she takes off to go to the doctor'. That's the problem. (Participant H, Interview 1).

These participants did not disclose in the attempt to portray a competent self at work. There is the inherent need not to be perceived as different from the norm, due to the perceived advantage of being regarded as 'normal'. It is, thus, perhaps unsurprising that where participants also had a physical impairment, they preferred to keep BPD undisclosed. This is evidenced in Participant C's narrative below:

They never looked more deeply than my physical stuff anyway, so I was quite able to hide any mental health issue. (Participant C, Interview 1).

Participant C had little or no choice with regards to disclosing her physical impairment, but chose not to disclose BPD. This was largely related to the perceived need not to add to the existent stigma attached to physical impairment. The participant further notes how non-disclosure may be a function of the previous experiences of the lack of understanding:

When I have been depressed, they have been like 'oh just pull yourself together, just get out of bed, go out'. That's not really helping, so I don't tend to share that side because even if people are really good, they say wrong things ...so I find that hard to share. I've tried sharing, but it just doesn't work. (Participant C, Interview 1).

Generally, participants did not disclose due to the fear that co-workers/managers will begin to question their competency, the fear of experiencing stigma, receiving differential treatment, and missing out on career prospects. The majority simply wanted to be considered capable and comparable with non-disabled colleagues, and the choice not to disclose was largely related to the need to conform to notions of competence and non-disability. Participants' fears may well be justified, as even in the absence of disclosure, several had had adverse experiences of work, such as task restriction. Participant A narrates such an experience:

I didn't disclose, and I think one of my main worries was that interesting work will be taken away from me. [Like where I worked initially], they were trying to stop me seeing certain users, and they were the people I found most rewarding to work with, ...[they gave me] the sort of job where you were supervising people doing what they could do. (Participant A, Interview 2).

The participant had her workability and competence questioned, due to the suspicion that she had a MHC. This may be due to the aforementioned somewhat visible nature of BPD. Her narrative points to how having what is regarded as a stigmatized identity can result in relegation and exclusion in the workplace:

I felt the decision was being made for me, instead of a discussion. And, I felt we could have had an open discussion about it [the change in work], if they hadn't already concluded I couldn't do it... I felt boxed in a corner, that's part of the reason I left. (Participant A, Interview 2).

As noted in the literature review chapter, workplace discursive practices emphasize competence and non-disability, hence, disclosing BPD may be challenging for employees with the condition. Non-disclosure, however, came at a cost for participants, as in the absence of disclosure, there were no provisions for accommodations. Participants had to self-accommodate. This resulted in what Hochschild (2003) terms emotional labour, with participants having to put up a façade at work in order to disguise symptoms. Participants' experiences of emotional labour are discussed in the following sub-section.

5.3.2.1 Emotional labour

One of the means adopted by participants for sustaining a non-disabled identity at work is through impression management. Impression management, according to McGinn (2009), refers to the acquisition of an 'acting role', whereby employees present to the public, the 'contented' rather than the 'distressed' self. It was employed by the participants of this study, with several attempting to present a competent self at work, in spite of personal emotions. As a result, participants had experiences indicative of Hochschild's (2003) emotional labour in the workplace. One participant likens their experience of teaching to an acting role, and notes the need to 'act' in order to mask BPD symptoms:

You try to, if you like, be an actor. You try to learn how to seem high, when you're not high, and that sort of thing. (Participant B, Interview 2).

Participant B notes how, even before diagnosis, he had mastered the art of seeming 'high' when low, and vice versa, demonstrating the inherent need to present a 'normal'

self at work. This is indicative of impression management, as the participant sought to perform a desired version of the self, even when this may not be the real version of the self. Other participants had similar narratives:

I feel when I'm at work, I'm having to perform, I'm having to ...not be someone I'm not, but having to emphasize certain parts of me, and kind of keep other parts at bay, and it's quite draining socially. (Participant A, Interview 2).

Participant A notes the impact 'performing' at work has had on her. There is evidence of how such actions may also affect social interactions, given that social interactions entail some form of mutuality and mental engagement. Emotional labour also seemed to impact on identity. Participant B describes such an experience:

[At home], my children would say can you speak to us a bit quieter. You got used to that volume of projecting your voice [while teaching]. (Participant B, Interview 2).

For Participant B, the constant change in 'self' between home and work resulted in a collision between the public and private selves, with the workplace façade extending into experiences of the 'self' outside of work. In some extreme cases, the workplace façade took over the self outside of work, as demonstrated in this narrative:

But after a while, because you've been acting that role for so many years, you forget who you were, and you can't remember who the real you was, and it's almost like you're doing things to please other people, being the person that other people wanted you to be. (Participant B, Interview 2).

The adoption of an act, in this case, seemed to result in the loss of a sense of self for the participant. These narratives are suggestive of how, in the process of concealing BPD and conforming to the norms of the ideal employee, BPD employees may lose a sense of self at work. Emotional labour may, therefore, impact on identity, causing emotional dissonance. Aside from the impact on identity, there are indications in participants' narratives of the other means through which keeping up 'appearances' could be tasking. For instance, participants had to put in effort and extra work, in order to maintain a non-disabled identity. For some, this meant not missing work:

I've been there over two years now, I've not had a single day off sick ...I can't ...and certainly the first year, I can't be seen to go off sick, because that will then put a dent in me being reliable. (Participant A, Interview 2).

Participant A sought to present a competent image of self, and suppressed whatever effects BPD may have on her performance in the absence of accommodations. Her narrative is indicative of the need to avoid being tagged as different or incapable, which inherently connotes the need to fit into the role of the 'ideal' employee. Such aspirations are often brought on due to the normative nature of work, a context where taking sick leave is perceived as an exception to the norm. In the bid to present non-disabled selves in the workplace, participants self-accommodated, using up considerable energy. In spite of the effort it took, the majority of the participants expressed no regrets in the decision not to disclose due to the perceived benefits of avoiding stigma and discrimination. Narratives were, nevertheless, indicative of the continued efforts to meet up with normative expectations in the workplace. Participants' narratives of non-disclosure in this section can, therefore, be conceived as means for accessing social approval via the adoption of strategies that enable them become a part of the prevalent social group. This is pertinent given that participants are situated within discursive practices which position the standard employee as one who is not disabled.

This sub-section examined participants' experiences of emotional labour, and how participants manage impression in the workplace. Given the significant stigma attached to MHCs, attention has been paid in literature to this subject area, particularly to the different tactics often employed by employees when managing non-disclosure in the workplace. This section of the analysis, however, offers a more in-depth examination of participants' experiences of emotional labour, and examines how impression management tactics may impact on BPD employees emotionally. More importantly, the study suggests that the need to adopt an act in the workplace develops due to the nature and structure of work. The context of work largely featured in participants' narratives of disclosure, and experiences after disclosure were relatively dependent on the nature of work. It was one of the major factors found to influence participants' disclosure decisions. This will be examined in the next sub-section.

5.3.3 Influence of work contexts on disclosure

The influence of the wider context of work was evidenced in participants' narratives of disclosure. The three sectors (private, public and third) were represented in the study,

with the eight participants having worked in diverse organizations, and performed different forms of work. These contextual features were found to contribute to variations in meaning. Participants who work in the third sector, particularly in MH support organizations, experienced more support after disclosure than participants in mainstream organizations or the public sector. For instance, of the eight participants, three work in MH support organizations, and one in a counselling organization. All four participants note that the context of their current jobs has made disclosure easy, compared to previous workplaces. This seemed to largely be a function of the nature of work conducted in their workplaces, which possibly rendered colleagues a bit more receptive to ‘difference’. Participants themselves noted this:

Because of the work we are doing, because we work with vulnerable people, because part of our job is to try and reduce the harm caused to vulnerable people, everyone has got really good hearts. So they just want to help... my organization really values difference, so they are really good to me. (Participant G, Interview 1).

The same participant became emotional in the second interview when talking about the support received from colleagues. Other participants who work in such organizations had similar narratives. One participant had moved into a new job role just before the third interview, and relates that while she has often not disclosed in previous workplaces, she did in the current workplace due to the nature of work done there, which is related to counselling. Talking about how colleagues had been accepting after disclosure, she notes:

I think it's because of the type of work though, and that's why, I think if it was another type of work, it may be more difficult. (Participant E, Interview 3).

This participant was emphatic during the first two interviews about not disclosing at work. She relates the change in her disclosure decision to the nature of work carried out in her current organization. As mentioned earlier, this suggests that individuals with BPD may experience more acceptance in particular work contexts than others. More importantly, it is indicative of how organizational discourse impacts on the acceptance culture within organizations. The nature of work is largely a function of organizational discourse, and the discourse in these organizations seemed to largely revolve around the acknowledgement and acceptance of MHCs. This may explain the higher level of

acceptance demonstrated by colleagues. Participants note how their organizations actively support and acknowledge difference. For some, this was in the form of having training programs aimed at developing an awareness of ‘difference’ in the workplace:

I deliver autism awareness training at work, because ten percent of the workforce have autism, so we want the whole organization to know and understand... I really want to put across [that] people are different. (Participant A, Interview 1).

There is a shared effort within such contexts to make the workplace receptive of difference. The levels of acceptance experienced seemed to be a function of the emphasis on acknowledging difference. Particular contexts may, for this reason, be more receptive of disclosure than others. In essence, where organizational discourse revolves around acknowledging and accepting difference, there will probably be more acceptance for BPD employees. This suggests that BPD employees may need to seek for particular types of work in order to be accepted at work, and highlights the structure of the labour market as a delineating factor between individuals considered disabled and those considered non-disabled.

Participants’ narratives in this section highlight the vital role invisibility plays in the experiences of BPD employees in the workplace, and its contribution to the exclusion that BPD employees may or may not experience. The narratives point to how BPD may be produced within processes of disclosure as ‘difference’, due to the adverse connotations associated with the condition. Having a choice seemed beneficial, as participants were able to evade discrimination and stigma and adopt ‘non-disabled’ selves at work. Presenting non-disabled selves, however, had adverse effects, and resulted in strain for some. Organizational response was also found to be somewhat dependent on the nature and context of work. Particular organizational contexts were more accepting of MHCs. Essentially, the section underscores that participants’ experiences of disclosure may largely be a function of the nature/context of work.

One of the major reasons people with invisible conditions disclose in the workplace is to secure work accommodations, as disclosure allows for adjustments to be made in the context of work to suit employees’ needs. The following section considers the degree to

which disclosure resulted in workplace accommodations for participants, and examines participants' experiences of securing work accommodations.

5.4 Workplace support

Having examined participants' experiences of disclosure and non-disclosure in the previous section, this section explores participants' specific experiences of work accommodations. First, it is vital to note that the need for accommodations was often brought on due to the pace of work, alongside increased expectations of productivity. Participants' narratives highlight how the changing nature of work in contemporary organizations may place demands on employees. For instance, one participant relates his experience of working overtime:

It was kind of, well, if you can't do it in the time [given], then that's your problem, you're obviously not working fast enough or hard enough, so there was a degree of pressure in getting stuff done. (Participant B, Interview 2).

Participants' narratives highlight the sense of urgency often found in contemporary organizations, perhaps due to the need to remain competitive. Several note that the atmosphere at work lays emphasis on getting work done. This is further demonstrated in narratives describing the emphasis placed on achieving organizational goals, at the expense of other facets of work:

I just remembered the director where I was working ...we actually got together and said look we are stressed, we've got too much work, and she went 'I don't want to know about it'. (Participant E, Interview 1).

Organizational needs are seemingly placed above those of employees, which would naturally result in challenges for all employees regardless of difference. It seemed to have a disproportionate effect on participants, perhaps due to the need to retain some form of balance for the sake of well-being. The increased pressure resulted in stress, particularly where participants had not disclosed. Disability, thus, occurred due to the application of similar standards for all employees. Several participants note how organizational demands/expectations proved disabling:

It was just get your job done. I tend to overwork and become ill, and maybe having to take about a week off a year. It seemed like a pattern. (Participant E, Interview 1).

While Participant E seems to assume the blame for overworking, the need to do so was brought on due to organizational expectations, and standardized levels of performance. Another participant notes how the pace of work resulted in a BPD episode:

I've had a workload that was unmanageable, and that was one of the reasons that tipped me over the edge [into a manic episode] I believe. (Participant D, Interview 1).

Participants' narratives highlight how workplaces may inherently have expectations of non-disability from all employees, regardless of difference, resulting in the disablement of employees with BPD. The need for accommodations was brought on in several cases due to such expectations of performance and productivity, demonstrating how the contemporary constructions of work may be of less benefit for BPD employees. The major forms of accommodations needed by participants include a phased return to work, allowance for creativity, putting up barriers separating workspaces, and having the liberty of working from home. Even where participants did not have accommodations, several identified the need for flexibility, work breaks and a quiet place to work without distractions. Experiences of work accommodations, and availability varied from one participant to the other. For some participants, accommodations were provided upon request:

It's more things like early referral to occupational health, flexibility, and remote working, so I can work from home, or I can work from another office. If I'm feeling unwell, I can either go on meditation breaks; also I can lay my head. And what they are going to do at the moment is find a creativity outlet, so if I've got any ideas what I tend to do is, I've got to talk about them now ...so they are trying to find me somebody I can book some time with, and talk about my idea, and they can say yes that's a good idea, or no forget about it. (Participant G, Interview 1).

Participant G's narrative indicates that she is a creative employee, and brought value to the workplace via her creativity. Her perceived 'value' seems responsible for the willingness of her organization to make provisions for accommodations. Participant G comments on this:

They were really keen to keep me at work, because even when I'm [not] well, I'm fast. I really enjoy my work, so I'm quite productive ...so as long as I don't ask for anything ridiculous, they will try. (Participant G, Interview 1).

Participant G suggests that accommodations were readily made available on the basis of the value she adds to the workplace. She demonstrates a sense of accomplishment, due to such workplace achievements. These notions are replicated in Participant H's narrative, when she rationalizes the support she receives at work:

I did have the advantage that I was very much the subject matter expert in that [area], and I was doing a really good job, and they wanted to keep me, and I had very nice and understanding management... I know people who have been dismissed, I'm lucky that I have specialized skills. (Participant H, Interview 1).

Both participants believe that the support they receive is a function of their contributions at work. This indicates that participants may need to demonstrate their value in the workplace, as organizations may only value employees (particularly those with impairments), to the degree to which they bring value to the organization. Proving value within normative contexts could, however, prove difficult, and BPD employees can be disabled through these means within the context of work.

Four of the eight participants have worked without accommodations at some point in their career. This is for several reasons. There were participants who did not request for accommodations because they felt they did not need accommodations. Participant H, for instance, states that for the major part, she is not in need of accommodations:

I don't actually need it, you see, for example, if I'm really ill, I simply cannot work. If I don't have an acute episode, my residual symptoms are not to the point where I need accommodations. (Participant H, Interview 1).

Participants perceived the episodic nature of BPD as beneficial, as they are optimally functional the majority of the time. Hence, there was no immediate need for accommodations. In addition to having no need for accommodations, participants also noted that the invisibility of BPD promotes the perception that they are not in need of accommodations. Participant H describes how her colleagues have not witnessed her having an episode:

The thing is people see me doing my job, and they see me doing it effectively, and they think okay, she's been sick, but they haven't seen it. (Participant H, Interview 1).

Such participants found the episodic nature of BPD to add to its invisibility in the workplace. Again, participants found this beneficial, as they were able to work, the majority of the time, without accommodations. Aside from the participants who had no accommodations due to the lack of need for one, there were also participants who had not disclosed, and therefore, could not request for accommodations. Such participants' narratives affirm that workplace accommodations are a function of disclosure. One participant, for instance, needed accommodations in the workplace, but could not secure accommodations due to non-disclosure:

I needed assistance, and I wasn't given any, so that's one of the reasons why I became so frustrated, that I disclosed my condition. (Participant D, Interview 3).

Participant D was compelled to disclose in order to secure support. This affirms that in the absence of disclosure, BPD employees may be unable to secure accommodations. As aforementioned in the literature review chapter, the nature of the Equality Act 2010 necessitates employees to disclose and acknowledge the need for support, in order to secure accommodations in the workplace. Other reasons for not having work accommodations relate to the need to avoid 'standing out' at work. Participants expressed the need to evade being perceived as 'different' by colleagues:

Before, I worked at a desk near a window, I had a little screen to go up beside me, so that when I was feeling like I was starting to get more manic, I would put the screen up to make me less distracted, and I could focus more on my work. I scrapped all that, because I didn't like it. I feel like it makes me stand out, draws attention to me. (Participant G, Interview 1).

What I needed was a quiet place to go; I don't have that where I am, at my work now. Sometimes, I think it will be really nice to have an office of my own, I can close the door, put my head down and rest, because if I do it in my office, [they will be like] are you alright? Even if I take my glasses off to rest my eyes 'are you alright?' (Participant A, Interview 2).

The emphasis, for these participants, is on avoiding accommodations that draw attention to their MHC, even if the attention is misguided. Several preferred to negotiate the workplace without accommodations, where accommodations would have required working in a manner that deviated from the standard way of working (Williams and Mavin, 2013). As above-mentioned, this is suggestive of the need to conform to the normative means for carrying out tasks, even where workplace norms differed from

participants' desired approach to work. For some participants, such feelings of diffidence were brought on due to previous experiences. One participant recalls the experience of requesting for workplace support, which was interpreted as disruptive by colleagues:

I asked to go part-time towards the end of a job, and I was allowed to do, but it was seen as a bit of [smirk], because it affected the rest of the workers [and the work rotas]. I was told we are going to have to ask people to do nights that normally don't do nights, people will moan, ignore it. I did feel a bit guilty. (Participant A, Interview 2).

This highlights how delineations may occur in the workplace due to the need for work adjustments, and due to the perceptions of participants' requirements as 'different'. More importantly, it points to the inherently ableist processes found in organizations, which may not recognize the legality of providing adjustments for BPD individuals. The majority of the participants sought to avoid such 'perceived' deviations. Where this was impossible due to the vital need for accommodations, some experienced guilt as evidenced in the narrative above. Such participants seemed to personalize the need for accommodations, even though it is very much a function of the work environment. Finally, there were participants who did not request for accommodations due to the nature of work in their organizations. Participant A describes how the nature of work in her organization is not supportive of particular accommodations:

There are other things I do, organize training, deliver training, and I would love to be able to do research for the training at home, or from a café or something, someplace that wasn't my work, but it's like 'no no no we don't do that here'. I think sometimes it's quite hard to concentrate at work. I think sometimes when I'm feeling a bit low, actually just doing it from home might be easier, not bother with the commute, but it's kind of contrary to where I work. (Participant A, Interview 2).

The participant did not request for accommodations due to the perception that the nature of work in her organization is contrary to the sort of accommodations she requires. Again, this points to the vital role played by the context and nature of work in participants' experiences of the workplace. Where the nature of work is inflexible, organizations may be less able to construct a notion of capability for employees considered different from the norm (Foster and Wass, 2012). It is vital to note that the absence of support, in such instances, may, itself, result in disability.

For the participants who had provisions for work accommodations, the majority requested for flexible working hours. The following sub-section examines this major form of work accommodation adopted by participants.

5.4.1 Flexible working arrangements

Five of the eight participants work part-time, or have requested for flexible work at some point during their career. Even where participants work full-time, this seemed to take some effort:

I do need to take time in the evening to rest. I had to sacrifice my social life, so it takes a lot of management and effort to keep working full-time. (Participant H, Interview 2).

Where participants requested for flexible work, their requests were often approved, and for these participants, flexible work has been valuable:

[It's] really helpful, like, the flexible work is really one of the main things ...I use the flexible hours that I've accrued while I'm well, to rest while I'm potentially unwell. (Participant G, Interview 1).

Participant G notes how flexibility has been one of the major means through which she has been able to work. It proved particularly beneficial due to the episodic nature of BPD, and she notes that her organization allows for accrual of hours in advance, for when she experiences episodes. Other participants had similar narratives. Several note that they are unable to conform to normative working hours structured around nine-to-five, five days a week. Requesting for flexible work was unavoidable for such participants:

I really can't see myself being able to work five days a week. I'm working four days now, and I almost think I'll try to keep the four days. (Participant A, Interview 2).

I'm much more able to regulate things, because I changed my life, really stopped working full-time. (Participant E, Interview 1).

There is evidence in both participants' narratives of the vital role played by flexibility in their 'workability'. The need to work flexibly was, however, brought on in many cases due to the inability to conform to normative working hours structured around full-time work. This is affirmed when participants note that even though they worked flexibly,

problematic expectations exist in the workplace, of performance and productivity. Several of their workplaces were found to demand comparable performances from all employees, regardless of flexible working arrangements. Hence, while working flexibly, participants often felt the need to work outside of working hours, in order to meet organizational goals:

I worked three days, but working part-time is just a really weird way to work ...because you end up doing a full week's work in three days, and by the time you get home ...it was exhausting. (Participant C, Interview 2).

Participant C's narrative highlights the pressure that normative expectations in the workplace may place on individuals who are 'different'. Participants found that while working flexibly, they are yet pushed to work more due to the need to match up to standards. This resulted in stress and strain for some. High expectations and standards seem to particularly apply to professional and managerial roles, as evidenced in this participant's narrative:

I was working 72 hours a week and that wasn't sustainable, so I said to them, look my contract says a total of 35 hours, and that's all I'm doing. [Because there were] managers that would do more, and we get brownie points for that. (Participant B, Interview 2).

The participant further states, when asked if they were paid for working overtime, 'oh no, it was just expected'. Participant B's narrative highlights how higher level managerial jobs may demand more hours of input, as employers have expectations of far-reaching devotion to work from employees in these positions. BPD employees may, for this reason, be obliged to keep longer working hours, in order to conform to the notions of the ideal employee. Working long hours did prove restrictive for Participant B. According to the participant, it triggered a manic episode. Such practices may, therefore, serve to delineate 'ideal' employees who work full- and over-time from BPD employees who work part-time.

It is important to note that BPD employees may themselves opt for less demanding positions, even where the jobs have less room for growth. According to Foster and Williams (2014), such individuals may, at times, limit themselves to particular jobs, which they consider suited to their skills; jobs where conforming to standard

organizational processes will be more manageable. The majority of the participants of this study, for instance, work in professional roles, which are often associated with flexible organizations, while one participant had previously been self-employed. The experiences of BPD within normative work contexts may, for this reason, influence participants' choices of work. The self-employed participant highlights this when she notes the ease experienced at work:

It's a lot easier, because everything is so more flexible. If I wanted a day off during the week, the options were there. (Participant C, Interview 1).

There is evidence of the particular flexibility attached to self-employment. The participant did find herself in this position due to necessity, rather than opportunity. She notes this:

Everybody sent me to the Disability Person's place. That was such a shock after university, where I'd felt completely ...I just had no worries about getting a normal job in a typical place, with mainstream colleagues. But then they kept on sending me to the Disability Services, disabled places... so I started my company. (Participant C, Interview 1).

The participant narrates experiences of 'othering' and differentiation after finishing school, which resulted in the inability to obtain a job. As a result, she decided to begin a business. There were adverse aspects to this, as the cost of accommodations, and cost of work in general became the responsibility of the participant (Foster and Williams, 2014). This proved challenging and she had to close down the business after a change in the UK government, as funds were no longer forthcoming:

The change of government and cut backs in services meant that ...I woke up without a job. I woke up, and the job was gone. (Participant C, Interview 1).

Hence, self-employment may not always be a viable option for BPD individuals. This notwithstanding, a major theme that emerged was the effect of BPD on participants' choices of work, as evidenced in Participant F's narrative:

I think working part-time has affected me, but I will definitely go for part-time jobs. (Participant F, Interview 2)

The majority seem to favour organizational contexts where conforming to norms or performing up to expectations may be more achievable.

This section examined participants' experiences of workplace support. The narratives in the section highlight the normative structure of work, and indicate how work accommodations may be interpreted as deviations from normative means of work, resulting in the 'othering' of BPD employees. BPD employees themselves are found not to often request for accommodations, due, either to non-disclosure, or the need to not be differentiated from the norm in the workplace. Where participants had accommodations, they had more positive experiences of work. However, the major form of accommodation, flexible work, also seems to have had adverse effects on participants' careers. The study posits that the disadvantages experienced by participants are due to the inherent suppositions of capability, flexibility, and work built around notions of non-disability. The analysis in the section points to the construction of work around normative and ableist norms.

Participants' overall experiences of work are often shaped via social interactions. Workplace support and accommodations, for instance, have to be negotiated within the context of social interactions, and the availability of such facets of work may be a function of social relationships. This facet of work is particularly pertinent to the study, given the social relational perspective adopted. The next section examines the social processes which develop in the workplace, as a result of BPD.

5.5 Social interactions

This section explores the impact of BPD on social relations, and how notions of 'difference' are produced/sustained within social interactions in the workplace. Participants had varied experiences of organizational response and social interactions in the workplace. For the sole participant with a physical impairment, social interactions proved to be a function of the 'gaze':

What I've found most difficult is the kind of face to face stuff, so other people might not have a problem with me, but I kind of believe they have, and I'm continually anxious and worried ...they drain my whole nature. (Participant C, Interview 1).

The physicality of Participant C's impairment appears to induce feelings of vulnerability, and her narrative is suggestive of some self-surveillance and internalization of the disabled identity. She further describes experiences of social responses due to the physicality of her impairment, which connote a deviation from the norm:

People are asking you in the supermarket if you are okay, and you just feel out of place. (Participant C, Interview 2).

The participant notes how she experiences social exchanges with non-disabled individuals within a context where she is perceived as reliant and different. There is an evidence of differential treatment and reactions from people within public spaces. While such responses may be demonstrative of sympathy and assistance, they nevertheless serve as a reminder to Participant C that she differs from the norm. Disability can result from such social relations, influencing an individual's sense of self, bringing about limitations set at a personal level, as illustrated in Participant C's narrative. Other participants had similar narratives after the disclosure of BPD. The supposed integration of 'symptoms' into the self, and the resultant behaviour which is perceived as outside the 'norm' impacted on social relationships, both personal and in the workplace. One participant narrates the experience of losing a friend after a manic episode:

When I was building up to my mania, I behaved in a way that is not socially acceptable ...so she kind of started distancing herself from me. (Participant G, Interview 1).

The majority experienced social responses indicative of an inherent desire to dissociate from individuals perceived as 'different'. Such responses also occurred within the context of work. Managers, in particular, were found to have a significant influence on how workplace experiences are interpreted. For instance, there are participants who experienced negative/disabling managerial relationships after disclosure, and this impacted on their general experience of the workplace. One participant describes how they have not been promoted for years due to managerial response:

[It's] probably down just to that relationship I had with the manager ...because he saw me at my lowest episode, and obviously marked me down as a lunatic, and I

think that's why my career has not ever [risen], rather than my ability at work.
(Participant D, Interview 3).

The participant's manager witnessed him during a manic episode, and the participant perceives that, as a result, he has been denied several opportunities for promotion. Again, this may be representative of a lack of understanding in Participant D's workplace, and a socially averse view of MHCs. The reaction is largely related to the perception of difference from workplace norms, particularly with regards to standard behaviour. This suggests that particular norms exist in contemporary workplaces for acceptable behaviour and standard proficiency. Where participants deviate, this may result in adverse experiences of work. More importantly, the participant is disabled, in this case, due to the restrictions placed on their career growth as a result of an adverse managerial relationship, the repercussion being that he had begun searching for another job by the time the third interview was held. Several participants had similar narratives demonstrating the impact of managerial relationships on workplace experiences. For some, this was in the form of micro-management, with participants noting a change in perceptions of their ability after their manager got to know of the condition:

I did have a series of incidents at my workplace, where I did disclose to my boss, my supervisor, and after that, she treated me dreadfully ...She began to question my work, which hadn't been an issue before, but she began to question [the] things I'd done. (Participant E, Interview 1).

Participant E disclosed to her manager, who she considered a friend, and notes that the relationship broke down after the disclosure. As aforementioned, where BPD is not fully understood, there is often the tendency to automatically relate the condition to the reduced capability to work. This is evidenced in Participant E's narrative, as there are insinuations of incompetence from the manager. In addition, the participant experienced pejorative remarks from her manager. This, for instance, involved experiences of being belittled in front of colleagues:

I think because she knew that I was ...that I had this mental illness ...one time I was off for a couple of weeks, and I came into a meeting, and she went 'oh here's [name], she's just been in a mental health hospital'... and there were other people there! (Participant E, Interview 1).

These narratives are demonstrative of how employees may experience a breakdown in relationships and discriminatory attitudes in the workplace due to BPD. Where managers adopted such medicalized notions of incapability, participants faced different challenges. The managerial response received by Participant E, for instance, had adverse effects on her experiences of work, as she eventually quit the job, and took legal action against the manager. Aside from these experiences of direct discrimination, there were participants who also experienced covert discrimination within the context of work. One participant describes such an experience:

My very first job was quite difficult emotionally for me. So, my manager figured out there was something going on, and he was quite supportive in a way, but he was always looking out in case I would be at risk. So he'd be kind to me, and then he'd be kind of looking out 'oh you alright, you might do some ...you might hurt somebody, you might harm somebody'. So it was a bit kind of difficult. (Participant A, Interview 1).

The manager's response is indicative of paternalistic tendencies, as he presents a caring stance, but institutes a surveillance system to ensure that the participant does not 'harm' anyone. This underlines the perceptions of unpredictability and incapacity attached to MHCs. The participant notes how work subsequently became challenging, thus, highlighting how disability may result from adverse managerial response. This is even more applicable where managers are responsible for the provision of work accommodations and support. The disposition of managers to the provision of workplace support could be crucial in such cases, for determining the degree to which employees with BPD will be able to function optimally at work. For instance, an adverse managerial relationship meant the lack of accommodations for Participant D:

I have continually not been given the support I require to do my job, and have had resources taken off me by the senior manager who saw the state I was in first time around. (Participant D, Interview 1).

BPD employees may ultimately become disabled at work due to such managerial response. It is, of course, important to note that managerial response is a function of the organizational preparedness for supporting MHCs. Where there are no organizational provisions for supporting BPD employees at work, managers may have little control

with regards to offering workplace support. Some participants noted the absence of formal structures in the workplace for MH support:

I actually helped set up a group [where I worked], to look at how people should be reacted to when they behave in this sort of way, and I said well, what's your current policy, and they said 'oh, we call the police'. And I said well, have you thought how provocative that is, if someone is absolutely, you know, in a state, the arrival of people in uniform doesn't actually calm them down. (Participant B, Interview 1).

The participant's narrative points to the possible lack of preparedness in contemporary workplaces for managing employees during BPD episodes. Within such contexts, even if managers were supportive, they may be restricted due to the absence of formal arrangements for supporting employees. Some participants did have good relationships with their managers at some point during their career. The majority note how a sense of affirmation was obtained due to having such support:

My boss then, she was one of my best bosses ever, and she was always cheering... she was always looking for the good in you, she always tried to encourage everybody, and she was very good at [that] ... and I always felt quite motivated by her, and quite affirmed, I suppose, by her. (Participant A, Interview 2).

Where participants had positive managerial relationships, their overall experience of work was positive. Having an understanding boss increased the likelihood of having understanding colleagues, which ensures having support in the workplace. Participants felt enabled in these instances, further highlighting the vital role played by managerial response in either enabling or disabling BPD employees in the workplace. Aside from managers, the participants of the study had varied experiences with colleagues in response to the condition. There is evidence in participants' narratives of how relations with colleagues may change due to BPD. Participants, for instance, noted instances where there seemed to be some wariness from colleagues after they learned of the condition:

I think there was a kind of common thing, a bit wary, it was more like kind of being careful around me, and it's one of these things, because I never said why are you being careful, I would just sense it. (Participant A, Interview 2).

There seemed to be some perception of unpredictability from colleagues, indicative of the general preconceptions of individuals with MHCs as unsafe and unpredictable.

Aside from demonstrating such wariness, there were also colleagues who, after learning of the condition, seemed to be on the lookout for changes in behaviour, and often served as the first ‘pointers’ to participants:

People will say you’re spending lots of money, or you are talking really fast, or you’re very excited. (Participant G, Interview 1).

In such situations, colleagues seem to be watching out for symptoms of depression or mania. While Participant G found this somewhat helpful, it became onerous and tasking, as she was unable to express any form of excitement without being accosted. Participant G describes how care from colleagues, at times, becomes stifling and frustrating:

Sometimes, it feels like they judge me too quickly. So, [for instance], I’ll feel like I’m mildly hypomanic, I’m fine, [and] I can manage, but they’ll start welfare. And I’ll feel like I’m being ganged on, and I want to have more freedom, and they are trying to push me down ...so they are trying to be nice to me, they are trying to look after me, but at times, it feels like I’m being treated with kid gloves, and I don’t need to be. (Participant G, Interview 1).

While colleagues may indeed care, such actions often result in some form of differentiation in the workplace, with the participant, in this case, being inadvertently placed in a ‘needy’ role, regardless of her capabilities. Participants may, as a result, experience ‘disability’ due to BPD in the workplace.

The analysis in this section provides insight into the social influences involved in participants’ experiences of the workplace. Narratives highlight the vital role played by social relationships in the workplace on the experiences of work, and point to how disability may result from organizational response. Organizational response was found to be largely influenced by stereotypical assumptions of reduced performance, and suppositions of difference. These responses delineate BPD employees as the ‘others’ in the workplace, as evidenced in the perceptions of deficiency and incapability from colleagues and superiors. From a social relational perspective, such analysis illustrates how marginalization occurs within social interactions on the basis of BPD, and underscores that social relationships play a major role in the transition from BPD (impairment) to disability.

The chapter set out to examine participants' experiences of securing, maintaining, and returning to work after sick leave. Having examined the first two facets of work, the next section considers participants' experiences of returning to work after sick leave.

5.6 Return to work

This section offers an examination of participants' return to work (RTW) experiences. This is particularly relevant to the study given that BPD is often related to a higher tendency to take time off work. The majority of the participants of the study have taken time off work at some point due to BPD episodes. Several note how their RTW experiences were largely dependent on how well they were received when resuming work. Participants found it easier to return to work where there was support for returning employees. The major form of support provided for the participants of the study is the 'phased return':

Occupational health has been fantastic. They do phased return, so I only work half days, so it is easier. (Participant G, Interview 1).

In 2009, I had a phased return, I built it up gradually, and that worked quite well. The following year I was off for eight months because of the mania, and, again, I didn't experience any problems on my return. (Participant H, Interview 1).

For these participants, the provision of support systems made returning to work a positive experience. On the other hand, there were participants who had less positive experiences of returning to work due to the lack of support. Two participants, for instance, faced 'notions of incapability' on returning to work after time off for BPD. There seemed to be some perceived reduction in value. One participant describes how they were offered phased return, with the expectation that they will subsequently retire:

I'm talking to the head of HR; she said to me that what usually happens is that people go part-time, and then they take out a retirement. And that seemed to be what she was expecting. And certainly, all of the individuals I'd come across in my time there, who had had breakdowns, they tended to be gradually moved out. (Participant B, Interview 2).

There is the perception that the BPD employee is incapable of returning to full-time work, or returning to work at all. The organizational response was presented via a paternalistic stance, implying that working full-time may not be beneficial for the

participant. The employee seems to have little choice, other than to accede. In addition, the organizational response highlights a medicalized view of MHCs, evidenced by the fact that there was no reference to how work can be made accommodative for the participant, except for the standard offer to go part-time. Another participant narrates the experience of having their work capability questioned on resuming work:

There was one time where I'd taken some time off on a sick leave; I'd been off for two months. I was in a temporary promotion, and when I came back, they had made a decision that they were going to take the temporary promotion and give it to somebody else, and I was going to go back in my previous role. And it took me about six months to convince them that the stress in my previous role is as stressful as being a manager, it's just a different kind of stress, so putting me in my previous role isn't going to stop me from having episodes. (Participant G, Interview 1).

Participant G experienced doubt from superiors on her capability after sick leave. Again, the organization adopted a paternalistic stance, and sought to reduce the participants' experience of 'stress', by reducing her responsibilities, in effect, demoting her. Participants' narratives here are suggestive of how organizations may justify particular actions as reasonable due to perceived health and safety benefits, or the welfare of employees. Participant G eventually regained the post, but this was after demonstrating some resistance, and proving herself 'capable'. Re-integrating into work proved somewhat challenging for these participants, due to the lack of support.

Another theme that emerged in participants RTW experiences relates to the direct correlation between organizational response and the condition for which participants went on sick leave. Participants often sought to keep the reasons for their sick leave undisclosed in the workplace, and cited less stigmatized conditions. Several noted that they do not declare BPD when taking sick leave:

I think you get normal sympathy if you break a leg, or you've got the flu. I use that to my advantage. (Participant C, Interview 1).

I've always asked doctors, and generally, they are nice, I mean, if I am signed off, put down anything but mental health. Put fatigue, or you know, put down stuff like cold. (Participant A, Interview 2).

The majority acknowledged that employees returning from an absence related to BPD may face less favourable responses from colleagues and employers, compared to individuals with other conditions:

I've seen it in people who signed off with mental health problem[s] coming back. Sometimes, it's kind of an embarrassment, because of the stigma around it. (Participant A, Interview 1).

This is further proven in participants' experiences of resuming work from time off for less stigmatized conditions, such as cold or flu:

It was just like, 'are you okay, are you overly infectious, are you going to pass it on to anybody?' And I'd say yeah...no...I'm fine, and then it'd be straight into, well this is what you do today, and this is the change since last time. They'd update you ...you know, there wasn't much kind of concern about it. (Participant A, Interview 1).

Participants' narratives point to how organizational response after sick leave may largely be a function of the nature of impairment for which an employee went on sick leave. There seemed to more openness when participants had been on sick leave for physical conditions, compared to MH-related leave. Participants themselves were more concerned about returning to work where time was taken off for BPD, compared to when it was for other conditions such as cold or flu.

This section examined participants' experiences of returning to work after sick leave. Essentially, the section illustrates that where support is made available, BPD employees have positive experiences of returning to work. On the other hand, where there is a lack of support, employees have adverse RTW experiences. This, again, highlights the importance of the work environment in shaping the experiences of BPD employees.

5.7 Conclusion

This chapter presented the first part of the research findings, and discussed the themes that emerged from the data collected. The chapter provides an in-depth and nuanced perspective on BPD employees' experiences of securing work, staying in work and returning to work after sick leave, with emphasis on the structure of work, the aim being to investigate the degree to which work is accommodative of difference. As aforementioned, the chapter addresses the following research questions: *How do BPD*

employees experience securing and/or maintaining employment? How do BPD employees experience work in settings intended for non-disabled employees? What does the experience of BPD in the workplace indicate about the normative structure of work? and How can BPD employees' narratives contribute to an understanding of the social relational model? The chapter addressed the first question directly by examining participants' narratives and experiences of securing/maintaining work; the other questions are addressed by investigating participants' work experiences within normative and ableist relational contexts.

The chapter accomplishes two things. First, the chapter presents a comprehensive analysis of how the normative structure of work may disable BPD employees. Participants' experiences were placed within the context of work. Placing BPD experiences within such contexts helped provide some understanding of how disability may result from the nature of work. There is evidence of how the conflicts between organizational norms and participants' abilities, which are often sufficient when used in suitable contexts, may result in disability for such individuals. This is further highlighted in participants' narratives on the challenges faced in the effort to adapt to the normative standards inherent in the construction of work. BPD was portrayed in contrast to the 'ideal' employee, and participants' narratives are indicative of how work is often structured to suit non-disabled employees. The connotation of BPD employees as incapable has had resultant adverse effects on participants' experiences of work. In the absence of such adverse connotations, and with the provision of adequate support, participants were found to have positive experiences of work. The chapter inherently critiques the ableist practices prevalent in contemporary organizations, and highlights the need to direct modifications at the context of work within which BPD employees are interpreted as deviant, rather than at the individual.

Secondly, the chapter follows existing social relational theories on how disability may be produced/sustained within the social relations that occur in ableist work contexts, and highlights the significance of social relations in the building of a sense of self. As noted in Chapter two, previous studies on BPD have often adopted medicalized perspectives. Emphasis has been on interpreting disability to be the result of impairment. This chapter

takes a different approach, and adopts a social relational stance. Normative standards were found to be upheld by colleagues and superiors, and dispersed via social interactions, with organizational response largely revolving around the assumed ‘inability’ of BPD employees. Due to such adverse organizational responses, several participants experienced exclusion and ‘othering’ in the workplace, with resultant effects on the ‘self’ as discussed in the next chapter. Where organizational response was positive, participants had positive experiences of the workplace, and felt enabled, thus, illustrating how disability may result from adverse social relationships and the organizational response in the workplace.

As aforementioned, the social relational model is two-faceted. This first analysis chapter addressed the first facet of the model, wherein ableism is taken to be produced and sustained within normative work contexts and social relations. The next chapter explores the second facet of the social relational model, which underscores how ableism is sustained within social interactions, with resultant effects on the sense of self. The chapter takes social interactions to be the product of discursive practices, and investigates the degree to which organizational response and participants’ narratives are shaped by wider discursive practices, with resultant effects on participants’ subjectivities.

CHAPTER 6 Discursive contexts of participants' experiences of Bipolar Disorder in the workplace

6.1 Introduction

The previous chapter established the normative nature of the workplace, and underlined that BPD employees' experiences of work may be a function of normative work contexts. This second findings chapter completes the study's analysis. The chapter adopts a structured approach to narrative analysis alongside Foucauldian analysis for exploring power influences and considering the emergence of subjectivities. The discursive influences in specific participants' narratives are explored, and participants' experiences are placed within wider discursive frameworks. Given that the study adopts a post-structuralist standpoint, emphasis is on how participants adopt different discursive practices when constructing and interpreting their experiences, and the resultant effect of these on participants' subjectivities. Subjectivity, here, refers to the considerations/feelings experienced by participants, largely related to a sense of self, and the approach adopted towards developing an interpretation of one's self relative to the world (Clark, 2001). Through the analysis of two participants' interviews, the chapter addresses the following research questions:

1. How are BPD individuals' interpretations and experiences of work influenced by discursive practices in the workplace?
2. How do BPD employees position themselves in the workplace?
3. How can BPD employees' narratives contribute to an understanding of the social relational model?

According to Williams (1984), stories often have causality, there is a beginning, probably in the past, which proceeds chronologically to an end, in essence, a past, a present, and a future. The study adopts this chronological structure, in line with Richmond's (2002) chronological approach to narrative analysis, and begins with past experiences, moves on to the present, and then the future. The structure is outlined in Table 6.1 below. Interview data largely followed this structure, and where this was not the case, the three phases were used for organizing participants' narratives, thus ensuring chronology. It is, of course, vital to note that past experiences are interpreted in

the present, and may take different connotations on the basis of the current temporal and social contexts. The chapter is structured in two sections. Each section discusses a participant's narrative using the structure depicted below.

	Social (Family)	Work	Self
Past Experiences	<ul style="list-style-type: none"> • Roots • Personal history 	Past work experiences	<ul style="list-style-type: none"> • Background • Self-identity • Roles
Present Experiences	<ul style="list-style-type: none"> • Current support 	<ul style="list-style-type: none"> • Current work experiences 	<ul style="list-style-type: none"> • Current status
Future Intentions	<ul style="list-style-type: none"> • Future support 	<ul style="list-style-type: none"> • Future work expectations 	<ul style="list-style-type: none"> • Personal development • Self-identity

Table 6.1: Organization of a Story (Adapted from Richmond, 2002)

Richmond's approach has been modified to enable an examination of participants' constructions of previous experiences from the present, highlighting the influence discourse may have on such constructions, and how subjectivities may result at the intersection between diverse discursive practices. For this reason, each section begins with a discussion of the relevant details in participants' stories of growing up, leading into a discussion of diagnosis and experiences after diagnosis, particularly at work. Participants' current experiences at work, and future aspirations are then examined. As discussed in Chapter four, two participants' narratives were selected for analysis in this chapter. The participants' stories are considered largely different from each other, seemingly representative of the two ends on a 'spectrum' of BPD experiences. The two participants were diagnosed at different junctions in their lives, one later in life, the other, earlier. One demonstrates resistance for the major part of their narrative, while the other demonstrates acceptance. Both participants were also considerably open during the interviews, and gave rich accounts of their experiences prior, during, and after diagnosis. In essence, while the two narratives differ in several ways from each other, and from other participants' narratives, they are considered representative of the basic

facets of other participants' narratives. The narrowing down of research to one or two participants follows the pattern often adopted in narrative and discursive studies. In Mancini and Rogers's (2007) study, for instance, two participants' narratives were selected of six for analysis. According to Mancini and Rogers (2007), the two participants were selected in order to underscore both the consistencies and dissimilarities in the discursive practices adopted by participants when narrating their experiences. Narrowing down the analysis to two participants in the current study should allow for a more in-depth consideration of participants' experiences. It is also important to note that particular parts of participants' quotes are highlighted (**in bold**) in the chapter where reference is made to them in the subsequent discussion. The following section examines the first participant's story.

6.2 Ian's story

First, this section examines Ian's experiences while growing up, leading to the diagnosis of BPD. Subsequently, his current experiences and future aspirations are examined. Emphasis is on the degree to which a sense of self develops based on previous experiences of medical, social, and organizational discursive practices, and how this has informed the current/future self. Ian, a man in his 60s, was a teacher/lecturer for the major part of his life. He is recently retired, and serves as a member of the board of directors for a MH organization.

6.2.1 Growing up and choosing a career

Ian had what he refers to as a 'settled childhood'. He was an only child, and notes that he was doted upon:

*I mean I... **obviously** as a child, as an only child, as I was, you think that you are a little bit special or something, you know. (Interview 1).*

He uses terms such as '*obviously*' to underscore a narrative that conforms to the norm. He mentions enjoying the privileges that come with being an only child, and had little to say about this stage of his life. He further positions his childhood as standard in his narrative below:

My parents always encouraged me to be very religious, you know, got me into the choir, all the rest of it. And, I think there was that 'oh he's such a good boy', and that sort of thing generally for me. (Interview 1).

Ian presents his early childhood as uneventful, and adopts the notion of normalcy when narrating his experiences of growing up. Having finished school, he began to pursue a career in teaching. He subsequently taught in a number of high schools before taking up a teaching position, which he maintained until he retired. In the bid to examine how particular subjectivities may develop, participants were asked questions regarding their life choices during the interviews. Reflecting on why he chose a full-time job as a teacher at the time, Ian states:

*With male colleagues, I don't think we would have [worked flexibly] at that stage. This is my generation; I don't think that we would have considered going part-time. We were the **breadwinners**, and our wives, **if we were lucky**, would have a job as well, or a part-time. Sometimes they might have full-time, highly unlikely. Nowadays I think you might have, well you're earning more than me, so I'll stay home and look after the kids. That wouldn't have happened. It's something that is changing... I think that was the main driver. I didn't want to, I didn't have the ambition to get a really well paid job as a headmaster, because that wasn't what I wanted to do, you know, [but] that is **probably what most people would have said you should be doing**, 'in years, you should be planning your career moves and things', but it wasn't something that really motivated me. (Interview 2).*

Ian's response is indicative of discursive practices related to profession, class and gender. With regards to class, working class women often work. Ian's narrative, thus, indicates he belonged to a class more accepting of the gendered discourse of men as 'breadwinners'. His decision to teach full-time can also be interpreted as largely influenced by gendered discursive practices around the role of men as breadwinners (Kelan, 2008), and women as carers. Ian demonstrates an awareness of such norms and draws on gendered discourse, positioning men as the providers, and women as the family carers. His use of terms such as 'breadwinner' and wives worked 'if we were lucky' (highlighted above) are indicative of this. He alludes to how he conformed in order to obtain social validation, and seems to attain a sense of masculinity due to the ability to work full-time. Ian does highlight in his narrative that the discursive context of the UK society is changing, and his stories may not apply to contemporary social contexts given that there are increased opportunities for women in the labour market. Working full-time and providing for one's family were, nevertheless, presented in his

narrative as a vital source of self-assurance, illustrating the vital role temporal discursive contexts may play in determining people's narratives.

Ian's gendered narrative is also intertwined with social discourse around the value of work and profession. There is evidence of how the norms surrounding 'success' and 'achievement' promote the importance of work in the construction of a valuable and professional self. He, for instance, mentions not having the ambition to get into teaching, but decides to get the job given that it is *'probably what most people would have said you should be doing'*. His narrative indicates that particular normative expectations may exist with regards to career choices; his choice of profession seems to be linked to the need to conform to such norms. This points to the influence social discursive practices may have on people's subjectivity, and the role of discourse in shaping Ian's identity as a man. Essentially, Ian's choice of career seems related to the social/gendered discourse which pertained during the time he grew up. He draws on gendered discursive practices when interpreting his experiences, signifying how a sense of self is constructed as a function of available discursive practices. His narrative is, thus, indicative of the impact classed, gendered and temporal discourse may have on people's subjectivities, and the manner in which people narrate their stories within the confines of accessible discourse. Having examined Ian's narratives about growing up and choosing a career in this section, the following section examines the degree to which Ian's narrative reflects wider discourse, evidenced in his experiences leading up to the diagnosis of BPD.

6.2.2 Journey to diagnosis

Ian received the diagnosis of BPD at the age of 52. While he seems to have had no knowledge of the condition before the diagnosis, on reflecting back, he notes that BPD has probably always been a part of his life:

Well, it came very late in life, I was... [age], and looking back, I think it was probably true I was bipolar all my life. But it was never picked up, and it was hidden, I suppose, basically because I might have worked the advantage of the highs, if you like, the hyper-state of being very productive. The crash when you come down from that high, I kind of managed to get that to coincide with holidays, so I always sleep through the holidays. I held down a job as a teacher for [many] years. (Interview 1).

The structure of Ian's job during the period seemingly helped to manage what he terms 'highs' and 'lows', which may indicate that particular jobs are more suited for BPD employees than others. He had no thoughts about having a MHC during the period, and notes that he had little contact with the medical profession:

*People didn't pick it up; I mean the family, I think, were probably... they got used to it. They accepted that I would sometimes just fall asleep on the couch, and not take interest in what was going on. They weren't sort of saying, you know, we're not going to tolerate this, or you better go and see a doctor, or anything of that sort. I was never a person who interacted with [the] medical profession at all, so I didn't... I think until I had the breakdown, I'd actually had no time off work at all. I **just wasn't ill**.* (Interview 1).

He attaches a notion of normalcy to his moods at the time, adding emphasis by explaining his lack of interaction with the medical profession, '*I just wasn't ill*'. His perception of his moods did change upon diagnosis, indicating how perceptions change when people are made to understand that there is something 'wrong' with them. The change in Ian's sense of self is evidenced in the impact the diagnosis had on his constructions of previous experiences. He came to understand that the highs and lows he experienced may be interpreted as deviations from the 'norm', and generally demonstrates acceptance of these medicalized notions, evidenced in the application of the diagnosis as a framework for interpreting previous experiences. He, however, places more emphasis on social influences than medical when discussing what led up to the diagnosis. He, for instance, notes that several events occurred in his life at the time:

Well, leading up to that I think there could have been a number of things going on. One of them was, I was going through a divorce... we'd been together a long time. So, it was kind of, it didn't feel right that there should be a divorce coming... kids had grown up, gone to university, so there was a kind of emptiness syndrome thing. And I think that partly, you know, kind of precipitated what happened. So that was one thing that was going on in my life. The other thing was, because of that, I suppose, I was a bit of a workaholic, and so [my workplace] was open, well I actually put in about 72 hours a week, so it was open like nine to nine every day, and I was there all the time. (Interview 1).

Ian can be interpreted as drawing on the social relational discourse, evidenced by the need to place BPD within the context of social circumstances and relationships, rather than the self. He offers possible reasons, and rationalizes the events leading up to his diagnosis, indicating that the changes occurring at the time may have impacted on his

sense of self and mental health. Causality is seen to play a vital role in Ian's narrative, as with all narratives, providing the sequence within which a different identity emerged. In essence, Ian places his experiences within the context of his life at the time, further underscoring the vital role played by time and temporal discursive discourse in the development of particular identities. His narrative, in turn, illustrates how identity may vary across particular periods. When relating what eventually prompted the diagnosis, Ian notes that his behaviour at work started changing while he was experiencing the aforementioned social upheaval and marriage breakdown:

*I was becoming very imperious and telling people what to do, you know, 'THIS is nonsense!', like that, very angry approach, and not in any way sort of... not being diplomatic... I [also] went from being a very cold person, that didn't touch anyone, to putting my arm around them. **They felt something very strange was going on here, I don't know what that was, maybe it was a need for touch or something, just a human need**, but it wasn't deemed to be appropriate, not quite inappropriate touching, because it was just colleagues, it wasn't children or anything like that, it was just a change of how I saw the world. (Interview 1).*

Ian's workplace, as with the majority of workplaces, had norms with regards to expected behaviour and professionalism, norms which, from a Foucauldian perspective, could be means for regulating employees. Ian positions himself as deviant from such normative behaviour, but offers justification for his behaviour. Such justification is often found in narratives where the narrator perceives a deviation from the norm (Stephens and Breheny, 2013). He, for instance, sought to normalize the change in behaviour by noting that it was probably '*just a human need*' for touch, hence, reducing the implications his actions might have had in the workplace. Colleagues, however, did not perceive his behaviour the same way, evidenced by the statement: '*they felt something very strange was going on*'. According to Ian, his behaviour was perceived by colleagues as uncharacteristic of him and of wider expectations, and unwelcome in the workplace. The organization is seen to ultimately draw on medical discourse, and Ian was advised to go and see the GP:

*When my behaviour started changing, **they basically said go and see the doctor, there's something wrong**. People were saying, well you're not yourself, ...then basically the principal said to me, it's a choice, you either go to the doctor and get sorted out, or you can have a disciplinary hearing. You're saying things about your colleagues that you're not allowed to, you're not allowed to do this sort of thing.*

And, I was basically saying well that person's reliable, that one is not trustworthy, and that sort of thing... and of course you can't do that with your colleagues, it's just not acceptable... I was perhaps a little bit too candid, and that for him was dangerous. (Interview 2).

Ian provides causality for the visit to the GP, relating it to actions considered deviant in the workplace. His narrative highlights how norms may be sustained, and deviations determined via discourse in the workplace. His behaviour was highlighted and constructed as deviant by his colleagues and manager, and the workplace is seen to classify such behaviour as being part of his pathology. This is demonstrated in his statement, *'they basically said go and see the doctor, there's something wrong'*. Ian's narrative is indicative of how medicalized discourse may operate in the workplace as a means for differentiating employees who deviate from perceived norms. This is not to argue against the suggestion to seek medical help, as it may be good practice for managers to advise employees to seek medical help in such cases. The study simply points to the possible reliance on 'medicalities' in the workplace. Ian also seems to draw on such organizational discourse, and demonstrates subjectivity, for instance, via the use of terms such as *'dangerous'* to connote the degree to which his behaviour may have been out of place in the workplace. He, nevertheless, acknowledges the focus on medicalization, and notes how the response he received probably resulted in the manic episode he subsequently had:

I think if you can have some fairly progressive views about how to deal with someone that either goes hyper, or goes into some sort of total depression, rather than saying go off and get some medication, that you actually spend some time talking to them, and finding out what's going on in their lives, that might [not] have led to that [the manic episode]. (Interview 1).

Ian's narrative points to how 'medicine' is often a goal for individuals regarded as deviant, at the expense of contextual and social facets of individual experiences. By highlighting the medical discourse applied in his organization at the time, and laying emphasis on the context within which BPD occurred, rather than the pathology of BPD, Ian can be interpreted as drawing on the social relational interpretation of disability. He eventually went to see the GP in order to avoid disciplinary action:

I sort of thought, well it's not going to help me to get disciplinary, I thought, I'm just going to get worse, you know, so I would go to the doctors... strange enough,

although I was hyper at the time, doctors prescribed anti-depressants and I thought, 'strange'. (Interview 1).

Ian visited the doctors while 'manic', but received prescriptions for anti-depressants. His narrative is indicative of how subjective evaluations of observable behaviour and symptoms could result in the medicalization of personal experiences. This is more so given that there are no particular 'objective' tests (for instance, blood tests) for diagnosing BPD (Cox et al., 2014). Ian describes the experience of taking the prescribed medication, and becoming even more manic:

*I went completely hyper, I went beyond a stage where you can cope with... I decided I've got to get on the train, because I thought I was going to be sectioned, because I knew I was **not normal** and **behaving normally**. So I jumped on a train, and it's a twelve-hour journey down on to [name of town], so I stayed ... for two or three days, and I couldn't sleep, and I was staying awake all night... and they [the people there] said, can we take you over to see a psychiatrist, you know, if you don't do it voluntarily, it would be a section, so I said 'oh, I'd go voluntarily, and you know, they would get to the bottom of what it is'. (Interview 1).*

Ian adopts terms such as 'not normal' and 'behaving normally', which indicate the social norms on standard behaviour. His sense of self, constructed within the temporal context, is one which is accepting of the label of deviance. It is vital to note how this sense of self developed partly within social interactions at the time, highlighting the relational facet inherent in the 'self'. For instance, Ian receives 'advice' to go the hospital, and demonstrates acceptance of the need for the medical intervention. His experience is demonstrative of how the perception of self may be influenced via social interactions within specific temporal contexts. Ian ultimately went back to see his GP. This time, he was admitted and diagnosed with BPD; he stayed in the hospital for a month. Ian's narrative about the hospital stay is similar to what has largely been recorded in literature on the institutionalization of people with MHCs. He narrates the experience as follows:

*Well, that was like suddenly **tables had been turned**, and it was almost like inside the hospital was normality, and outside is madness, you know, that sort of feeling. It was a community, so **we** helped one another, and often you'd get a lot of information about the drugs that you're taking, about how you would get out of the hospital, how do you convince people that this is... you're better, and we'd still, we kind of like, **we** called it **going up before the parole board**, and you know, what **you** had to say and all that. So **you**... learned one line which was, 'I realize that if I take*

*my medication regularly, I would be okay', and that was deemed as showing insight. Well, all **you** 're doing there is learning your lines, not showing insight at all, whereas if **you** just said 'I'm feeling much better', they will double your dose. If you're saying 'I'm feeling pretty down', then they'd probably add some medication to deal with that. (Interview 1).*

Ian notes how he felt that the '*tables had been turned*', signifying that the hospital would often be perceived as the one occupied with 'difference', while the outside world is occupied with normalcy. He adopts plural personal pronouns such as '*we*', which connotes some deference to a shared mind-set and identity, and a sense of shared accountability with other patients. This way, he seems to delineate himself and the people in the hospital as essentially dissimilar from people in the 'outside' world, positioning them as different. He does apply the second-person language '*you*', possibly indicative of the need to separate himself from the context of the hospital/diagnosis, and its implications for the sense of self, or perhaps de-emphasize his experiences of the hospital. Ian, nonetheless, largely draws on the medicalized discourse of 'patient-hood' in this narrative (Mancini and Rogers, 2007), evidenced where he alludes to how patients had little choice other than to submit to, and be made objects of whatever medical label was given, in order to survive within the hospital.

Within the context of the hospital, Ian had his necessities defined via medical means, the justification being to rehabilitate and restore to the norm, a debatable notion and goal in itself. Several measures were put in place as evidenced in his narrative, to ensure submission and deference. Aside from what he terms the '*parole board*', there is also evidence of surveillance systems in the hospital in Ian's narrative. This is affirmed in his narrative when he notes that even though they were not necessarily being physically watched, he often had the feeling of being observed during his stay in the hospital:

I mean you get that paranoid on the psychiatric ward, where you're under constant observation. (Interview 1).

He further refers to the suspicion that the medical profession had 'moles' amongst patients, which seems to have had some cautionary effects on the behaviour of patients:

It wasn't evident whether they, you know, sort of, you might start to think they've actually got moles in here, you know, that sort of thing... (Interview 1).

Ian notes how patients began to suspect that there were secret informants amongst the patients, and were often uncertain if they were being surveilled or not, thus demonstrating the uncertainty experienced due to surveillance. His narrative is indicative of some self-surveillance which resulted from the fear of being watched amongst patients. In addition, the hospital seems to adopt a patriarchal system, evidenced by the need for patients to repeat lines before a '*parole board*', and the handing out of 'rewards' for conformity or discipline for nonconformity. From a post-structuralist standpoint, Ian's comments regarding the '*parole board*' (highlighted above), and having '*moles*' in the hospital generally illustrate how power may operate via medical language and discourse to produce objects of control (Morgan, 2005). Indeed, these systems are indicative of the Foucauldian form of power operating within the medicalized discourse of 'patient-hood'. As predicted by Foucault, Ian's narratives of the hospital are not devoid of resistance. He indicates that several patients resisted medicalized influences by reciting lines they did not mean. The development of resistant selves was further aided and facilitated by the relationships formed, and the 'us vs. them' mentality amongst patients. The inmates jointly, according to Ian's narrative, seemed to construct identities which helped them 'survive' the set restrictions of the hospital. Ian, in particular, demonstrates an attempt to maintain a sense of self in spite of hospitalization and medication. He mentions taking time out to research BPD while he was in the hospital:

When I did have days out from the hospital, they allow you passes of short term, I go to the library and research on the internet, and it struck me that, that [taking medication] was not what I wanted. (Interview 1).

Unlike the previous extract, Ian is seen to adopt the first-person language while narrating the part about taking up some form of action. He positions himself as an agentic actor, as opposed to a patient. He further notes:

I didn't discuss it [BPD] with any of them [family]. I didn't feel the need to. I did my own research into it, and read an awful lot of books on psychology and so on, to get my own take on it, to try and understand the condition... [I really didn't have any particular support]. Several years on, someone said 'who is your CPN?' [Community Psychiatric Nurse], you know, I didn't realize there was that... having said that I don't think I would have wanted it, I probably would have resisted. (Interview 2).

Ian's narrative seems indicative of a sense of self located at the intersection between gendered norms and the implications of BPD. On the one hand, the discourse of 'patient-hood' and the context of the hospital position him as reliant and disadvantaged. On the other, gendered norms demand fortitude, autonomy, and self-reliance from men. He is seen to develop a resistant sense of self within these contradictory discursive practices. Having carried out research on BPD, Ian positions himself as knowledgeable of the condition. He decides to stop taking medication on the basis of the understanding he developed from his research:

When I came out of there, I just said to myself 'I'm going cold turkey on this, I'm not carrying on with this'. (Interview 1).

There is evidence in Ian's narrative of a transition from the position of 'patient-hood' to one of agency. Having left the hospital, he sought to leave behind medical principles, and evade medicalized discourse. He was, however, unable to fully achieve this. He describes feeling like he was still being watched after he left the hospital:

They recommended six months of Haloperidol [an antipsychotic medication], and ...and all that kind of thing, and I just thought, no I don't want that, and I've got to find an alternative way of doing it. But the difficulty is that you're monitored by the health profession, so you have to be incredibly devious. And in my case, what I did was go and get prescriptions, but not actually get the drug, or use them, so there was six months' worth of prescription... [that] I picked. (Interview 1).

Ian demonstrates resistance to the perceived surveillance, and devised means for evading the medical profession. He eventually got signed off from the medical system, and was allowed to resume work after six months on sick leave:

*Then I went to see the psychiatrist, and he said, 'oh you seem to be ok... seem **recovered**, I think I can sign you off and back to work'. So, I went back to work. (Interview 1).*

The medical profession is seen to serve as 'gatekeepers' in Ian's story. He had to be signed off before he could resume work. More importantly, the use of terms such as '*recovered*' is indicative of the emphasis in medicine on restoration to 'normalcy', a state which may, in this case, be a function of Ian's productivity in the workplace. Ian describes how, upon resuming work, the assumption at work was that he was taking his medication:

Because I was living in [name of area], and they don't monitor people there, no one asked me, are you taking your medication, which is the normal thing if you go back to work, because they don't want the thing to reoccur. They don't want another episode, so they think if you take your medication, then that's okay, that's then covered, and to some extent, it's kind of an insurance thing... and I think in many professions, unless you agree that you were taking your medications, they wouldn't let you come back. (Interview 1).

His narrative is indicative of an understanding of how emphasis may often be placed on medical discourse in the workplace. He generally demonstrates resistance to such overriding discourse, and sought for alternative means for managing BPD:

For the past ...well since then, which is how many years now, sort of fourteen, fifteen years, I've not taken anything. So I managed the bipolar, if you like, but I worked out what the trick is. I worked out, you know, if I'm going high, how do I bring it down, if I'm going low, how do I bring it up, and that sort of thing. (Interview 1).

Ian believes that he has since then been able to manage the condition in the absence of medication. His narrative is, therefore, indicative of resistance to prevalent medicalized discourse on the need for medication when managing BPD. The agentic position adopted by Ian in these narratives is largely a function of the knowledge he gathered about the condition. It is, however, important to note that the knowledge garnered may, itself, be a function of medicalized discourse. Ian, for instance, demonstrates this when describing how he manages BPD:

I try to keep my health good by going to the gym, don't smoke, don't drink, so from that point, I have some good things on my side. (Interview 2).

Ian notes that one of the major means for managing BPD is exercising. Such alternative means, however, align with contemporary constructions of health as the responsibility of the individual, and are further indicative of the medicalized discourse on the benefits of physical activity (Warburton et al., 2006). Ian's investment in adhering to such guidelines for staying healthy is indicative of the influence discourse has in shaping peoples' subjectivities. He seems to challenge the prevailing means for managing BPD, which are essentially medicalized, yet draws on medicalized discourse in the construction of an agentic self.

Having examined Ian's experiences of diagnosis/hospitalization, and the means through which a sense of self may develop within available discourse in this section, the following section examines another segment of Ian's narratives, his experience of transitioning back to work after diagnosis.

6.2.3 Transitioning back into work

This section examines Ian's experiences of moving back into work after diagnosis, and aims to determine the degree to which his narrative is a function of the discursive practices adopted in his workplace. While diagnosis of any kind often represents a major turning point for many, it seemed to be a transitory disruption in Ian's narrative. He took some time off work, sought to return to work full-time, but had to take a six-month break, after which he resumed work. Ian notes that before he returned to work, his workplace had been informed of his diagnosis:

The psychiatrist that they wrote to at the hospital that I'd been at, he was very reluctant to give them the information they were asking for. They wanted a complete low/load down... and he just said, 'what I will give you is bipolar'; really all he will let them know. And I think then, they kind of put two and two together and made five, and said well, bipolar, that must be same as schizophrenia. I don't think they (colleagues and management) really had a concept of what the difference was. (Interview 2).

He narrates how his workplace seemed to attach similar stigmatized connotations to BPD and schizophrenia, probably due to the reduced level of understanding of MHCs during the time. His narrative is indicative of how people may often not make diagnostic distinctions when interacting with individuals with MHCs (Lazowski et al., 2012). He was positioned as different by colleagues/ management, and as a result, had several adverse experiences on resuming work. Some of these experiences are examined in the following sub-sections.

6.2.3.1 Discourse of reduced performance

On resuming work, Ian was asked to see HR in his workplace. His experiences, at the time, point to a phased return, as he was initially asked to come back part-time:

It was interesting, because the initial thing, I was told what you do is you go back, and you speak to the HR officer. And [HR said], now we've come across this in the

past, and people don't tend to come back full-time. They might come back part-time, but probably for a year or so, and then they take retirement on health grounds or something of that sort. And I said well, I don't want to follow that path, and so they said come back part-time. (Interview 1).

Ian was offered a phased return to work, after which he was expected to take an early retirement. The HR response narrated by Ian reinforces the discourse of BPD as a representation of inability, and supports the perception of Ian as dissimilar from his contemporaries. As noted in the previous chapter, there were ableist expectations of reduced performance evidenced in the organizational response received. The discourse produced through such HR practices often carries into organizational standards, which in turn influence the thought processes and self-realization of organizational actors, evidenced in Ian's narrative where he notes that the majority of the employees in similar circumstances have often accepted to move on to retirement:

*Certainly, all of the individuals I'd come across in my time there, who had had **breakdowns**, they tended to be gradually moved out [of the organization by management]. (Interview 2).*

Ian's narrative points to how different forms of employee identity, disabled or otherwise, may be constructed through organizational discourse, on the basis of perceptions of ability. Ian himself employs terms such as 'breakdowns', a further indication of the adverse connotations attached to MHCs in his workplace. He, nevertheless, adopts a resistive self, again demonstrating resistance to the idea of going on retirement. He accepts a gradual return to work, and is eventually reinstated to his previous position:

*So I came back part-time for a bit, did the job reasonably well, then they agreed. I went full-time and took my previous job, which was [title of job]. So I was in charge of [name], so I had staff that were working with me, and, you know, kind of just to **prove a point, I worked many years**. I think it's unusual, because you tend to get encouraged to think you're not now capable of working, and it was only, I think if I'd been on medication at the time, I probably would have accepted that. (Interview 1).*

Ian asserts that he maintained a competent self at work, noting how this was a function of not being under the medical influence. There was, however, evidence in his narrative that he was under some self-induced pressure to prove himself as capable of carrying

out his job. He, for instance, mentions working for many more years, in order to prove a point. He further highlights this when asked if he had any workplace accommodations:

No, [I did not request for accommodations]. I think it was more like I've got to prove I can still do the job, and so I have to get up, just to be there, I have to get up to what I was doing before. (Interview 2).

On the one hand, this may be representative of the need to present a non-disabled self, and divest himself of the disabled identity. On the other, Ian's narrative is indicative of the pressure which normative expectations in the workplace place on individuals who are 'different'. This is more so given that requesting for accommodations entails accepting 'difference' to be a permissible impairment (on the basis of the Equality Act). Ian generally resisted the notion of impairment, and seems to reject the dependent role often assigned to employees with MHCs.

Aside from the normative discourse of reduced performance evidenced in Ian's workplace, he also experienced surveillance on resuming work. His experience of surveillance is examined in the next sub-section.

6.2.3.2 Surveillance and the discourse of unpredictability

On resuming work, Ian believes he was being monitored by colleagues. He notes that he experienced surveillance from his colleagues and manager, and often felt like he was being watched:

I noticed that going back, it's always difficult to know to what extent you're actually paranoid, or whether your paranoia is being exacerbated by what your colleagues are doing. So, when I went back, I wasn't allowed to share the room with my colleague, and they moved me into a room where there was three other staff who I knew, they were kind of work colleagues, but I had a feeling that they were watching me all the time... it was a feeling of well, we're going to keep an eye on you, we're going to watch what you do on the internet, and the rest of it. (Interview 2).

Ian's perceived experience of surveillance is demonstrative of the power relations which facilitate differentiation in the workplace, contributing to the 'othering' of employees who are considered different. Ian himself notes in the narrative below that the surveillance was probably aimed at maintaining control, ensuring he conforms to normative behaviour:

I think it's a matter of control, I think they feel that, you know, if you've got some kind of loose cannon, you're not going to, or you've not got control as the management, so therefore, you know, they don't like a maverick. They don't like someone that doesn't toe the line, doesn't sing from the same hymn sheet, and so on. (Interview 1).

He acknowledges that the organization probably sought to retain some form of control and conformity where they perceived deviance. Again, he resists these techniques, and confronts his boss about not being allowed to return to his previous office:

*Well, I thought that... I'm not going to, I'm not going to give into this paranoia. I know it's happening, so therefore it isn't imaginary, I will fight it. And I went to see the... I said look what is this about, I've been told that I can't go back to my old workplace, I said, I'll go to a tribunal over this, you know, I want to make a point. And he said, well you won't get anywhere, he said, but I can tell you off the record, but I will deny it afterwards. I say, what are you going to tell me? I'll accept that I'm not going to take it any further, I just want to know what is going on. And he said, [name], who was one of my colleagues, thinks you will **go mad with an axe**... (Interview 1).*

As with previous portions of his narrative, Ian provides direct speech, seemingly detailing the discussion verbatim; this further underlines his position of resistance and agency. His narrative, however, suggests that his colleagues and manager developed particular notions of him, probably as a function of his behaviour before the diagnosis. This perception of Ian, in addition to what seems to be a lack of understanding of BPD, and the reliance on extant stereotypical discourse led to misconstructions of the condition, creating trepidation amongst colleagues. Given the post-structuralist perspective adopted in the study, it is vital to note that the language used in Ian's narrative, aside from mirroring wider discourse, equally establishes and creates new rationalities within the organization. There is evidence of how new, situationally placed and social constructed discourse, aside from drawing on predominant discursive practices, also gets legitimized within social contexts. Such legitimization is evidenced, for instance, when Ian's workplace made changes to his office space due to concerns that he will 'go mad with an axe'. There is evidence of the impact of such discursive practices/social relations on Ian's subjectivity. He demonstrates some subjectivity to the 'othering', as evidenced in his narrative below:

So I said well, you know, I thought in this day and age people weren't quite so quick to make those sort of decisions, but I would rather have the truth as to, you know, well we didn't think it would be a good idea for you to share the room with a female for the time being... I mean, I accept that it could be a danger if you were, you know, your mind was unsound, and that sort of thing, but to pretend it's for another reason, that was the thing that got me. (Interview 1).

Ian indicates acceptance of how he may deviate from medically defined norms. He was also accepting of the change in office. He does note how, in spite of the lowered expectations at work, he went on to work with the organization for several years before retiring.

Having examined Ian's narrative up until his recent retirement, the following subsection discusses Ian's present experiences and future aspirations.

6.2.4 Present and Future

Upon retirement, Ian joined the board of directors of a MH organization. He describes the organization as follows:

I'm involved with [name of organization], so I meet regularly with them, we discuss various issues related to mental health. (Interview 3).

He notes how the organization is particularly receptive of MHCs due to the nature of work carried out by the organization:

Disclosing in my current organization wasn't a problem, they benefit from someone with lived experiences, so that's why I took the job. All of us members have had mental health issues. (Interview 2).

The nature of work is found to impact on Ian's experiences with the current organization, and having co-directors who have also experienced MHCs seems to have contributed to a high level of acceptance within the group. With regards to how he currently manages BPD, Ian notes that he continues to manage the condition without medication:

I've had no problems. I changed my lifestyle. I go to the gym two/three times a week... I have a new wife, and it's a great relationship... the other thing is the creativity, you know, I've always sort of enjoyed playing music and so on... I just enjoy that side of it, the music side, and other creative things. (Interview 3).

Ian generally presents BPD as less central to his current sense of self, and inherently rejects non-disability as the determinant of his sense of self. His current experiences are reflective of the resistance evidenced in his narrative of the past. However, there is also evidence of continued resistance in his future plans, as shown in his narrative below:

One of the issues that I've brought up there is the issue of substitutive decision-making, because it's quite coming into [the] 'Human Rights' thing at the moment, and psychiatrists generally are very anti this, they don't like the idea of not being able to make decisions on behalf of patients, and the notion that they [patients] might have a say in that... Social workers have a similar attitude towards care that 'we know better'. I'm not saying that they all are like that, but quite a lot of them feel, you know, 'what do you know about this, we are far more versed in this...' It's not a case of right, let's all sit down together and work out what's best for you. (Interview 1).

Ian demonstrates knowledge of the reciprocity between knowledge and power. He notes how medical knowledge is applied for delineating disabled individuals as different, and underscores their need for management in the workplace. He plans to continue actively challenging such notions via his current organization.

In essence, particular discursive practices are seen to result in stigmatized social interactions in Ian's workplace, interactions that impact on the social context of work. Several subjectivities are available within any of these discursive practices, either in conformity or resistance. In the process of narrating his experiences, Ian is seen to negotiate a subjective position on the basis of available temporal, classed and gendered discursive contexts. He seems to conform in some instances and resist in others. He, for instance, conforms to gendered discourse, evidenced in the pride taken in working full-time, and providing for his family. Conversely, he demonstrates resistance to the ableist and medical discourse in his workplace. He generally adopts an agentic position, both within and outwith the workplace. Across the three interviews, emphasis was often on his independence and capabilities, and on managing BPD without medications, rather than the adverse effects of the condition, or dependence on medical discourse. He also continues to challenge medical discourse through his current organization, and demonstrates an awareness of the power influences/exploitative relations, which occur in the society. From a post-structuralist perspective, his narrative highlights how a sense of self may develop and vary from one social/organizational, classed or gendered

discursive context to another, illustrating how the past self may reflect or vary from the present.

As aforementioned, the chapter adopts a structured narrative approach for analysing two participants' narratives in-depth. Having examined Ian's narrative in the first part of the chapter, the next section turns attention to the second participant, Clara.

6.3 Clara's story

Clara is a woman in her late forties who currently works with a MH organization. She was recruited for the study through a MH support organization. During the first interview, Clara did not immediately begin with stories of growing up. She, however, later referred to her experiences of childhood, particularly when trying to explain the difficult relationship she has with her family.

6.3.1 Growing up

Clara notes that as a teenager, she displayed particular behaviour, which her family was keen to pass off as 'normal' teenage behaviour:

I was just seen as being kind of difficult when I was a teenager. Because the problem really started arising when I was about fifteen or sixteen, and my parents were very keen for it to be seen as just being a teenager, and I just needed to grow up and be more responsible. (Interview 1).

Clara narrates how her family sought to pass off her behaviour during teenage years as normative teenage behaviour. She relates this to the stigma attached to MHCs during the time (1970s/1980s):

I grew up in [...] where there was even bigger ...certainly when I was living there, in the 70s and 80s, there was a huge stigma, and I was terrified of going into the hospital. Every time I suspected it might have been a mental health problem, all I could see was this really big asylum that was about twenty miles from where we grew up, and I was terrified. And when I was in London, I was terrified of being locked up in [the hospital]. (Interview 1).

In retrospect, Clara is able to relate her experiences while growing up and her family's reaction to the context of the stigma that existed at the time. Her narrative here is largely a function of the discursive context of the period, which, according to Clara, was less

receptive of MHCs, and heavily medicalized. Clara notes that her family sought to avoid being associated with stigmatized ‘deviations’ from the norm. She describes some of the means through which her family kept her MHC hidden:

[If] they denied I had a mental health problem, then they didn't have to deal with the shame of other people, the neighbours, the wider family finding out. I think there was a shame, like if we don't admit it, if we say somebody was a bit odd rather than ill, if we say somebody had TB, rather than they were in psychiatric hospital... (Interview 1).

Clara's narrative on familial response is indicative of how personal and social relations may be influenced by social contexts/societal attitudes towards individuals with MHCs, and underscores the influence discursive contexts have on social interpretations of MHCs. Clara is seen to position herself as different due to the social/discursive context at the time, demonstrating how the sense of self may be a product of discursive and temporal contexts.

Relating the past to the present, as she often did during her narrative, Clara states that she continues to be regarded as different by her family:

*My family, even now, there's a kind of like I'm just being a bit contrary, and or being a bit odd, and if I really wanted to be **normal**, if I really wanted to... I didn't fit in... like they've all got very good jobs, they've all got mortgages, they've all got children. I rent my flat, I only got married last year, no children, no desire to have children. And even my job, which I think is a good job, is nothing [compared to] one of my brothers... he works with a big international IT company, he travels around the world, really lovely guy, but he just doesn't understand **why I've made the choices I've made**, and part of them haven't been choices. So yeah, there's a misunderstanding particularly with my family, and it's been difficult throughout the years. (Interview 1).*

She adds that when she goes for family occasions, she is often asked about these assumed choices:

*When I go for a family occasion... people say what do you do? And, you know, you married yet? **Do you want children?** You're so good with your nieces... and it's really difficult. (Interview 1).*

Clara's narrative is indicative of two discursive practices. First, her narrative illustrates the influence of medicalized discourse on the interpretation of BPD. There is evidence of medicalized interpretations of MHCs from her family, as they seem to individualize

the condition, and believe she has ‘chosen’ to be a particular way, or behave a particular way. This seems to also be related to the perception that she should be in control of her actions, and take responsibility for her behaviour. Such notions can be related to medicalized expectations of the standard individual as one who is balanced and rational. Secondly, Clara’s narrative intersects with gendered discourse on social roles. To a large degree, particular roles are often allotted to specific gender, and portrayed to be natural for such gender. For instance, social norms associate femininity with marriage and children (Ramsden, 2013). There is evidence of the normalizing influence of such gendered discourse in her narrative. Her decision not to conform to gendered roles, in addition to the ableist notions attached to BPD, seems to further underline her family’s perception of her as ‘different’. She portrays them as not understanding particular ‘choices’ which they seem to consider as non-conformist to social expectations. It is vital to note the interactional nature of gender demonstrated in Clara’s narrative. She, for instance, describes, while emoting frustration, how she is frequently asked if she wants children at family occasions, ‘*Do you want children?*’. Her narrative is suggestive of how socially constructed delineations may be reinforced within social relations.

While Clara demonstrates resistance to such perceived norms and resists ‘femininity’ as a determinant of her sense of self, evidenced in the decision not to have children, her choice of language suggests some subjectivity to socialized norms, and an internalization of norms. She describes her siblings as leading ‘*normal*’ lives, having conformed to social expectations, implying that she may be different. She is also seen to position herself as different from family members by drawing on social views of standard behaviour, and employed terms in her narrative to suggest that she is different from the norm. Her sense of self seems to emerge within the context of her family’s perception of her. This illustrates how gendered discursive practices may influence perceptions of the self. On reflecting further, Clara notes that her relationship with her family is much improved:

But, I feel a lot better around the family as a whole now... yeah, I think they’ve kind of accepted it more... there’s a bit more understanding, just generally in the air. (Interview 1).

She re-defines the relationship with her family in light of the increased understanding of MHCs within existing discursive contexts. From a post-structuralist perspective, such variations in narratives across both temporal and discursive contexts depict the vital role played by context in shaping a narrative.

To some degree, perceived delineations from the norm seem to have become a self-definition for Clara. Her narrative is indicative of how people may become inseparable from the social context. Furthermore, her narrative highlights that a sense of self/subjectivity develops at the intersection between social norms and gendered discourse. The analysis in this section, thus, illustrates the influence of discursive practices/contexts on the interpretations of experiences. Having examined Clara's experiences of growing up in this section, the following sub-section examines the next phase in Clara's story, her journey to diagnosis.

6.3.2 Journey to diagnosis

This section investigates Clara's experiences leading up to the diagnosis of BPD, and the degree to which she draws on particular discourse when interpreting her experiences during this period. As aforementioned, Clara positioned herself as different for the major part of her narrative. Aside from differentiating herself from family, she narrates how she often knew her moods were different from the 'norm', even before diagnosis:

*You can imagine a graph, and there was a line going across which is normal, and most times I kind of felt that I was under normal. And then every now and again, I went bang! past normal and peaked, and kind of crashed down again into depression. And I kind of think my normal was what I would have called a bit sub-par low... I didn't really have a concept of I was, I had bipolar disorder or... I wasn't thinking in those terms. I just felt **there was something wrong with me**, and in some way **I was faulty**. (Interview 2).*

Clara highlights the notion of 'standards', where a populace is expected to fall within a typical bell-shaped arc (Davis, 1997), and narrates how she often felt she was outside the arc or at one extreme of what may be termed a continuum of moods. She draws on medical discourse when narrating these experiences, evidenced in the use of terms like '*there was something wrong with me*' and '*I was faulty*'. Clara further demonstrates the

adoption of such discourse when she narrates an experience with a friend after a breakdown:

I said 'I want to go to the hospital... something is wrong with my brain, they have got to cut it out', and that was when he [the friend] said I think you're depressed, I think you really need to speak to somebody, I think you need to see a doctor. I really wanted to go to the hospital to cut my brain out, because it's not working. (Interview 2).

Her narrative is suggestive of an internalization and acceptance of medical delineations; she adopts this medicalized discourse for the major part of her narratives. Continuing her narrative, Clara notes how her eventual visit to the GP was prompted by her boss at the time:

*I was there maybe two years, but a part-time temp job contract, and I didn't tell anyone, but I was becoming quite paranoid. My boss noticed, so... he said go see your GP, because you're **not right**, you're **not well**. And so I went to the GP. (Interview 2).*

Clara, when relaying the response from her boss, adopts terms such as '*not right*' and '*not well*', which highlight the perception of MHCs as deviations from the norm. Such connotations of MHCs as deviation in need of normalization are indicative of medicalized discursive practices. Clara eventually visited her GP. The GP prescribed Prozac, and she recounts the experience of going back to see another GP when Prozac did not seem to improve her 'symptoms':

*I saw a different GP and she referred me to a psychiatrist... by this time the [first] GP had put me on Prozac, so I was really hypomanic, chatting away nine to the dozen. So, I went to the psychiatrist ...This is my theory, he thought 'oh you were depressed, you were on Prozac, you're happy now, so you must have been depressed, and Prozac is good for you'. [So he gave me a diagnosis of depression]. **That was my diagnosis** for a while, and I think I was actually hypomanic, induced by the Prozac. But I do remember looking in the mirror one morning, and for the first time in probably a year, actually smiling back at myself. And, it was quite moving remembering, just the sense that I wasn't bad. So, that was the kind of [a] start on me having a diagnosis, and feeling this fit. (Interview 2).*

Clara received the diagnosis of depression while she believed she was hypomanic; again indicating that the diagnosis of BPD may largely be based on subjective evaluations of observable behaviour. The prominence given to medical discourse does demand that

patients surrender their subjectivity, and adopt the objective realism found in medicine. This is evidenced in Clara's narrative where she personalizes the diagnosis: '*that was my diagnosis*'. She notes that after a while, the diagnosis of depression seemed insufficient. She describes how she eventually got diagnosed with BPD below:

After a while, that [depression] didn't quite make sense, because of what I was experiencing... And I was seeing a psychiatrist who thought that [BPD] might be the case, I think it was 2008, I was seeing a different psychiatrist, and she seemed quite clear it was a Bipolar disorder, Bipolar II. (Interview 1).

Clara subsequently received the diagnosis of BPD, and describes her immediate feeling after diagnosis as one of relief:

[I was] relieved, because what I'd suspected was what the psychiatrist was now saying. And the medication she prescribed... I had researched it, and it seemed to be the best... I was able to tolerate the medication, which was important, and... I've had a bit more balance. So, medication helped, it did, in fact, I felt I was doing a better job [at work]. (Interview 1).

Clara demonstrates acceptance of the diagnosis of BPD and medication. As noted in the previous section, this may be due to the framework provided by the diagnosis for interpreting previous experiences. She subsequently interprets the majority of her experiences within this framework, and is seen to often draw on medical discourse when interpreting personal experiences. For instance, she attributes perceived improvements in her 'workability' to the medication she takes. Even where she acknowledged the social interpretations of MHCs, Clara is seen to draw on medicalized discourse, as highlighted in her narrative below:

When I first got diagnosed, I met some other people who had a variety of other mental health problems. They were talking about whether mental illness was a disability, or was it 'difference', and I really got the idea of a disability compared to say an illness or a disease. That didn't make sense to me, because it was very psychological to my understanding. The social model which means to me that it's the external environment and other people that causes much of my problems... that's how I see myself. But I think... people are different, but they have got a disorder as well... so that kind of idea of it's a disability on one hand, but it's also a disorder, that there's something in it that needs to be managed, I do find medication helpful. (Interview 1).

Clara appears to adopt both social and medicalized discourse in her narrative. She identifies with the social model, but believes that BPD is a ‘disorder’ that needs to be medically managed. She largely demonstrates subjectivity, and accepts the need for medication in order to attain rehabilitation. It is, of course, vital to note that while the view taken in this study interprets Clara’s narrative as indicative of subjectivity to medical discourse, the study does not deny the realism of individual experiences of BPD. This is more so given that acknowledging the materiality of discourse is a vital facet of post-structuralism (Willmott, 2005). The study simply posits that the particularity of BPD as a concept has been built via discourse, and Clara has come to understand the condition as a disorder via the influence of discourse. Besides, Clara’s narratives could also be interpreted as agentic as she actively demonstrates an understanding of her need for medication in order to manage BPD. She mentions carrying out research on suitable medication. Her narrative is, therefore, not without agency. The following sections further develop on the discussion of Clara’s narratives, transiting from her past to present experiences. Emphasis is on the discursive practices found within the workplace, and the degree to which such discourse influenced Clara’s story.

6.3.3 Experiences in the workplace

Clara notes that her first job was at the age of fifteen, and while she has since changed jobs several times, she has had few experiences of unemployment. When giving an overview of her work history, she states:

I worked for [an organization] for two years, and then I went for a change of work, and so I got into social care. Initially, I worked with older people, and then I did two years in one job, and then five years in another job, then two years in another job... Then I got [my current] job, and I’ve been working in that place since then, [for] more than two years. (Interview 1).

Clara relates the frequent transition between jobs to several facets of work, but largely positions BPD as having had some adverse effects on both her work experiences and job prospects. She describes her experiences in between jobs and while searching for work below:

*When I've been looking for jobs to apply for I kind of go 'no', I could maybe do this job, but I'm not going to be the sort of person they want to do it, and I think it's part... I think the whole way jobs are advertised is obviously, you know, dynamic, passionate, things like that. And, if **you** haven't got, **you**'re not always going to be passionate, it doesn't mean **you** might not be tenacious or persevere, or things like that. But yeah, it's almost like they want super people, superman super woman, you know, when I've been applying for jobs, when I've been quite down, it's really difficult to get past that... I was looking at jobs last year, just to see what was out there, and jobs that kind of match [my] person's specs, and I thought [whispers] I can't go for this, because, you know, I had a sense they wanted something else. (Interview 2).*

Clara points to the preconceptions attached to BPD, and positions prospective employers' ideals and job specifications as opposite to that of an individual with BPD. She adopts the second-person language, seemingly positioning herself as different from possible deviations from the norm/ideal. She also accepts the possibility that she may be positioned as different from the ideal by others. Her sense of self develops, here, in relation to how she may be perceived by prospective employers. The resulting self-perception of deviance seems to have impacted on her experience when searching for jobs, dissuading her from applying for jobs she may have found fitting. Clara's narrative is also indicative of the ableist standards/procedures found in recruitment and selection processes; she interprets them as restrictive. The terms used in job adverts may, this way, come to be interpreted as inherent exclusionary techniques, which position the ideal candidate as one who is non-disabled.

Aside from recruitment processes, Clara's experiences in the workplace are representative of similar restrictions brought on by the construction of BPD as deviance. She had a job at the time of diagnosis, and had been encouraged to visit the GP by her boss. She subsequently visits the GP, and is diagnosed with depression. Clara then moves on to another job and, had adverse experiences in the workplace, due to suspicions that she has a MHC. She describes this experience:

[The year after diagnosis], I went into support work and social care, and my very first job was quite difficult emotionally for me. So, my manager figured out there was something going on, and he was quite supportive in a way, but he was always looking out in case I would be at risk. So, he'd be kind to me, and then he'd be kind of looking out... 'oh you alright, you might do some... you might hurt somebody, you might harm somebody'... so it was a bit kind of difficult. (Interview 1).

The actions by Clara's line manager, as described in her narrative, are indicative of paternalism. While he demonstrates care, there was emphasis on keeping her under surveillance in order to ensure she does not 'harm' anyone. From a Foucauldian standpoint, such surveillance often has adverse and cautionary effects on the behaviour of the observed (Foucault, 1997). For Clara, it made work more difficult and challenging. She was eventually asked by her manager to see the GP after an incident at work:

Once, one of the guys that'd come [into work] was quite a bully, he was not a very nice person, really got me worked up and angry. So that [day], my boss just said to come away, and he said, you're not just quite yourself... I know you've been upset in the past couple of months... he says, have you ever been diagnosed with clinical depression? I said 'yes, I'm on medication'. He said, I don't think it's working, you may want to go back. (Interview 2).

Again, Clara's narrative is indicative of the medicalized discourse of differentiation. The medicalized discourse was a theme in the majority of the places where she worked. Organizations applied the understanding obtained from such discourse when addressing MHCs. This resulted in several adverse experiences, and seems largely related to why Clara changed jobs several times. A particular discourse was found to exist for the major part of Clara's narrative of work which relates to ableism. Ableism is examined in the following sub-section.

6.3.3.1 Ableist discourse - the ideal employee

Before diagnosis, Clara notes that she did not disclose to anyone, as she had no knowledge of the condition:

I couldn't disclose anything because I didn't have anything to disclose. (Interview 2).

Upon receiving a diagnosis/label, she tends to disclose in the workplace:

Sooner or later, it comes out. I just find it comes up; it has to be spoken about sooner or later. (Interview 2).

Clara has had varying organizational responses to disclosure of BPD. Providing a cross-section of the managers and colleagues she has worked with, she relates how she

is often faced with adverse rather than positive responses in the workplace. She recounts these experiences below:

[After disclosure], I think there was a kind of common thing, a bit wary, it was more like kind of being careful around me, and it's one of these things, because I never said 'why are you being careful?' I would just sense it, and I think the reason [one of my colleagues] bullied me was because I was open about having a mental health problem. I think he saw me as less than other people, I was really a service user. And, I think he thought he could get away with it. So I think that was definitely some kind of stigma discrimination. I think [name of one of her managers] saw it as a strength with potential costs to me, I think [another manager], the boss who took me when I worked for the social worker, I think he saw it as a bit of a risk that he had to manage as a manager, to make sure I wouldn't harm any other people, but he didn't get rid of me, he was just wary and careful. Other jobs, [with] colleagues, I think it depends. Some of them were okay, and a couple of people would say yeah, I've been depressed myself. (Interview 2).

The majority of the time, the responses received by Clara are indicative of some form of 'othering' due to notions of difference. Her narrative underscores ableism in the workplace. In particular, she remembers an experience with a colleague, which she relates below:

I remember I had this woman, we worked together, [who I had a] very antagonistic relation with... we hated each other... and then she left. I bumped into her about a year later, and she's come up to me and went I want to apologize, and I said why, you know, and she said I've been off sick with depression, I had no idea [the woman said], I used to think why don't people just get a grip, you know? (Interview 2).

While this sentiment was not directed at Clara (it was directed at the service users they worked with), the sentiment reflects the responses received by Clara in the workplace. She had experiences where she was differentiated due to her MHC. An example was discussed in the previous chapter where her need for a change in work rotas was perceived as a disruption to standard work schedules. Clara's story is, therefore, largely embedded within discursive practices which frame the majority of employees as non-disabled, and frames disability as a deviation from the norm. From a poststructuralist perspective, Clara's narrative highlights how non-disability may be the only available positioning for employees in the workplace, particularly within social interactions/relations. The availability of particular discourse is seen to shape how Clara perceives/positions herself, and how she believes colleagues perceive her, thus

restricting the development of a more positive identity at work. She demonstrates some internalization of the experiences of ableism. For the major part of her narrative, she was emphatic about presenting an employable/non-disabled self at work, and laid emphasis on the need to avoid creating adverse perceptions of her performance. This is evidenced in her narrative below:

*With depression and anxiety, it was really important to me that even if people, if managers knew I had a mental health problem, I wanted to prove my mental health wasn't getting in the way of me doing my job. It was **very, very** important to me. (Interview 1).*

Clara is seen to use emphatic language 'very, very' as means for underscoring the importance she places on how she is perceived in the workplace. As aforementioned, this is indicative of the attempt to position herself as an 'ideal' employee at work. She further highlights this when discussing her experiences in another workplace:

I had a real sense that somehow I wasn't good enough. So, I'd been hired to do two half nights and half days, and I tried to get to do all night. Working at night was better for me, because I didn't have to interact with people. If I did have to interact with people besides the service users, it would be because there was an emergency... So I worked nights for almost three years, and I think the reason it suited me was because I could excuse me being tired and low by being exhausted, and that was ok, and it was understood, and I didn't feel so stigmatizing. (Interview 2).

Clara demonstrates self-vigilance for the major part of her narrative, and is conscious of how colleagues view/perceive her. Her narrative also points to how stigma develops within social interactions. She selects particular tasks in order to avoid interacting with people. In relation to this, she seeks to 'overcompensate' at work, possibly due to the need to measure up to organizational standards. This is evidenced when she rationalizes her choice of tasks in the narrative below:

I was working nights to make myself indispensable, because nobody liked working nights, and I was always on the weekend nights, Thursday, Friday, Saturday nights. And the reason I did that was, they'll be a bit more lenient with me, they will be nicer to me, because to cover those nights is really hard, and when I go on holidays and I come back, they will be even more grateful to me. And I do at my current job, I always do this, try and make it that getting rid of me is going to be very difficult, or trying to replace me is going to be really difficult. (Interview 2).

There is evidence in Clara's narrative of the pressure which normative expectations in the workplace place on individuals who are 'different'. Her experiences at work seem to restrict the degree to which an affirmative identity can be constructed within organizational discourse. She, for instance, accepts that MHCs are perceived as a disadvantage. This is seen to bring her sense of self as an ideal employee into contention, evidenced in her emphasis on presenting an employable self, and fitting into discursively defined notions of the ideal employee. She negotiates a sense of self in relation to these preconceptions and the discursive context at work, generally assuming a subjective position on the basis of how she is perceived by colleagues. The self-surveillance and internalization of ableist discourse impacted on Clara in several ways. For instance, with regards to work, she is often inclined to work part-time due to the perceived inability to work full-time. She also notes in the second and third interviews that she often settles for less challenging jobs due to reduced self-perceptions of what she is 'able' to do, and her abilities:

*I think it's been a thing in almost all my jobs, where I have been under-stimulated, and part of that, I went into jobs like that because I didn't think I could do anything else, but it kind of became a self-fulfilling prophesy. I don't think I'll ever have the kind of job I might have aspired to at one time, few years ago. I had bigger aspirations, I mean I've had aspirations that have been kind of high and sorts of things, so it's kind of like yeah, I can see myself doing this, and I know I had a thing like I would like to run a small charity... but now I don't think I could... a lot had to do with my ability to cope with stress, and how to do responsibility. If I'm the main person in the organization, I can't cope, it's a lot of responsibility on me, and it's a lot of risk for the organization. I once worked as part of a management committee for a charity organization, and even though other members did nothing, the fact that they will come if they were called on, the managers were both very **capable** people, but I don't want to be the main person, and that's kind of sad, that I've had to let go of that. (Interview 2).*

Clara's narrative indicates that individuals with BPD may, at times, limit themselves to particular jobs which they consider suited to their skills, due to the discursive constructions of BPD as 'inability'. She demonstrates an internalization of medicalized discourse, when, for instance, she positions herself as different from previous (non-disabled) co-managers, who she refers to as '*capable*'. The need to self-manage an organization may, itself, be demonstrative of an internalization of normative discourse around the ideal employee. The self-perception of deviance generated as a result

guarantees that no external force is required in order to ensure Clara submits to the medicalized notions of BPD.

Clara's narrative in this section highlights how the concept of self may be socially constructed within discursive interactions in the workplace. Clara ultimately secured her current job. Her experiences in the current workplace and future aspirations are examined in the next sub-section.

6.3.4 Present and Future

Clara narrates how she eventually got a job with the support organization she currently works with:

I finally got a job that was supported employment, and now I'm still in the same organization; I've got a job there. (Interview 3).

She notes how her current workplace is particularly receptive of MHCs due to the nature of work carried out by the organization:

A lot of our work is to do with mental health, so I got very comfortable at speaking about it. I think me being comfortable helped other people be comfortable, but a lot of people I know have their own mental health issues, depression, anxiety, whatever, over the years. So, I think I find around me now friends, who are people I kind of do things with, are kind of open. (Interview 3).

The context of work is found to impact on Clara's experiences of work in the current workplace, further illustrating how the sense of self/subjectivity may be influenced by discursive contexts. There is evidence in her narrative of how the increased acceptance, demonstrated via organizational discourse, aids in reducing the adverse connotations attached to BPD. This seems to have a positive effect on her narrative. Clara describes how acceptance is a focal point in organizational discourse in her current workplace:

I deliver awareness training at work, because several have autism, so we want the whole organization to know and understand... I really want to put across [that] people are different... which goes down really well. (Interview 1).

The development of acceptance within organizational discourse has had resultant effects on organizational ethos, and Clara notes how she often receives positive responses upon disclosing BPD:

There's kind of two reactions; one is like 'oh I've had a similar [experience]', and you kind of share a little bit of stories, and I've never had... it's been a long time since I had a very negative reaction. [Then], there's kind of like 'oh that's interesting, thank you for telling me' sort of thing. (Interview 2).

The willingness and ease of disclosure is indicative of an accommodating discursive context. Clara is seen to adopt a more confident sense of self. Her current workplace allows for the construction of a more positive identity at work. Clara does note that her workplace is unreceptive, to some degree, particularly with regards to making accommodations available. For instance, she notes that the nature of work makes it impossible to request for particular accommodations:

There are things I do, organize training, deliver training, and I would love to be able to do research for the training at home, or from a café or something, someplace that wasn't my work, but it's like 'no no no, we don't do that here'. (Interview 2).

While Clara relates this to the security systems adopted in her workplace: '*The work I could technically do at home, I can't do, because of security*', her narrative depicts how disability may result from the somewhat inflexible nature of work. She, nevertheless, seems content in her current workplace, and gives no indication of leaving the job. She notes that she hopes to secure accommodations in the future, which will further facilitate her productivity at work:

We've got a new HR manager at Head Office, so I think I might talk to her about [securing accommodations at work]. I think sometimes, it's quite hard to concentrate at work. I think sometimes, when I'm feeling a bit low, actually just doing [it] from home might be easier, not bother with the commute. (Interview 3).

She demonstrates the continued desire to perform well at work, and hopes to achieve this where suitable accommodations are made available.

This section examined the discursive practices evident in Clara's narratives, and the impact of such practices on her experiences of work. Clara's experiences seem to be the product of discourse, and when narrating her experiences, she largely drew on available discourse both within and outwith the workplace. Having often been differentiated at work and among family, she demonstrates an internalization of ableist discursive expectations, and is self-vigilant, with resultant effects on her sense of self. The

experience of differentiation is seen to impact on her aspirations and career path, evidenced in her choice of less demanding positions, and more flexible organizations. This is not to say that Clara solely adopts such discursive practices without resistance, as there was evidence of agency in her narratives. In essence, her narrative demonstrates how identities develop within the intricacies of either conforming to or resisting prevailing discursive practices.

6.4 Conclusion

This chapter set out to discuss the discursive influences in specific participants' narratives, placing participants' experiences within wider discursive frameworks. The chapter explored two participants' narratives, investigating how discourse constitutes facets of work and the people within it. Adopting a post-structuralist perspective, emphasis in the chapter is on the influence of discursive practices on work contexts, and on participants' subjectivities, evidenced in the way participants positioned themselves within available discourse. Narrative analysis was applied for relating participants' stories over time to social discursive contexts, particularly within the workplace. Discourse was found to both constitute and be constituted in participant's experiences of work. Both participants, for instance, have experienced workplaces that draw on the medicalized discourse of MHCs. Participants were delineated as a result, with organizations adopting several techniques for governing non-standard actions/behaviours, such as the surveillance of participants, techniques which resulted in differentiation and 'othering'. This ultimately impacted on participants' constructions of the 'self', thus highlighting how discursive contexts may influence/shape subjectivity. The way MHCs were interpreted/received in the workplace also influenced the sense of self, shaping not only thought, but also identity and subjectivity.

Both participants' constructions of the self alternated between acceptance and resistance of the discourse related to stigma, reduced capability, ableism and acceptance in the workplace. Ian, on the one hand, seems to derive a sense of self due to the ability to work full-time, and provide for his family. Conversely, Clara experienced 'otherness' within the context of her social relationships, due to perceived deviations from similar socially constructed gendered norms. From a social relational perspective, these

narratives highlight how disability and a sense of ‘otherness’ are generated within social relationships and discourse. Participants’ narratives also point to how the sense of self may evolve, over time, in relation to changing discursive contexts. Both participants grew up, received the diagnosis of BPD, and worked in differing contexts, and this seemed to have some impact on their interpretation of events. Clara began having ‘symptoms’ from a young age, and had a preconception that she differed from the norm for a long time. Ian, on the other hand, had no preconceptions of the condition until diagnosis. These differing contexts resulted in differing experiences of BPD, and participants are seen to position themselves in varying ways on the basis of the contextual and temporal discourse available to them.

The chapter highlights the subjective nature of BPD employees’ experiences in the workplace. Both participants’ narratives underscore that an individual’s identity may be as representative of prevalent discursive practices as it is of any distinctive character. The analysis in the chapter also contributes to Foucauldian research on the construction of subjectivities within ableist discursive practices, and develops further understanding of how power operates in the workplace via discourse, which impinges on employees’ constructions of the ‘self’. The following chapter discusses the findings in the current chapter, alongside the previous chapter, relating analysis to literature/theory, and directly addressing the research questions.

CHAPTER 7 Discussion of findings

7.1 Introduction

As aforementioned, the key aim of this study is to extend reasons for disablement in the workplace from individualistic forms of enquiry to social rationalizations and the discursively constructed nature of work. The research questions, as stated in the introductory chapter are as follows:

1. How do BPD employees experience securing and/or maintaining employment?
2. How do BPD employees experience work in settings intended for non-disabled employees?
3. What does the experience of BPD in the workplace indicate about the normative structure of work?
4. How are BPD individuals' interpretations and experiences of work influenced by discursive practices in the workplace?
5. How do BPD employees position themselves in the workplace?
6. How can BPD employees' narratives contribute to an understanding of the social relational model?

The first findings chapter, Chapter five, highlighted the themes in participants' narratives. The chapter underscores the normative nature of work in contemporary organizations, illustrating that the exclusion BPD employees experience may result from the perceptions of BPD employees as different from organizational norms. Chapter six explored how participants' narratives are influenced by prevailing discursive practices, and underscores the impact of discourse on individual interpretations. This chapter further discusses the findings, merging the two findings chapters, and relating them to existing literature, with the aim of addressing the study's research questions. The chapter is structured in five sections in line with the research questions, as shown above.

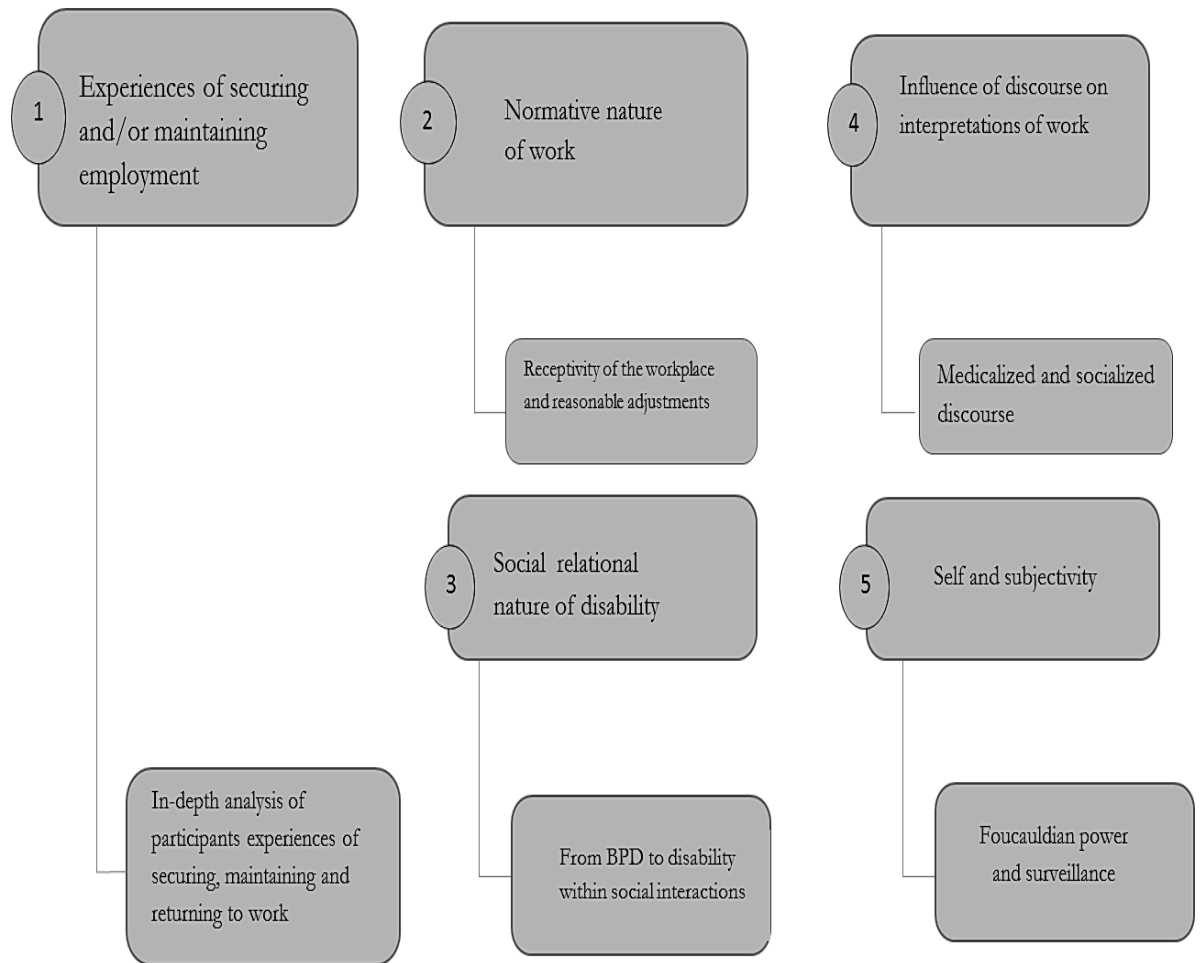


Figure 7.1 Key points in research findings

7.2 BPD employees' experiences of securing and/or maintaining employment

This section considers participants' experiences of work in three sub-sections, and addresses the first research question: *How do BPD employees experience securing and/or maintaining employment?* The section examines participants' experiences when trying to secure and maintain work, or return to work after sick leave. The aim is to offer an in-depth perspective on the possible challenges or difficulties faced by BPD individuals when attempting to secure work, and determine if/how the labour market and workplace disables/excludes BPD individuals.

7.2.1 Securing work

The data points to how experiences of discrimination during recruitment may often be a function of the physicality of impairment (Wilton, 2006). The evident nature of Participant C's 'impairment', for instance, pre-empted disclosure. Such upfront disclosure seemed to reduce employment prospects for the participant (Von Schrader et al., 2013), as she was unable to secure a job and had to start up a business, again, highlighting how the relationship between impairment and employment may be considered incongruent. The data also suggests that individuals with BPD may experience covert discrimination during recruitment processes due to how jobs are advertised. Some participants perceived job specifications as laying emphasis on idealized skills, and notions of what an ideal candidate should be capable of. The findings support previous literature on the inherently ableist nature of recruitment practices in contemporary organizations (Shier et al., 2009; Biggs et al., 2010; Harpur, 2014). According to Jammaers et al. (2016), job specifications which inherently mandate non-disability as a criterion are increasingly the norm. Applicants with impairment are discursively constructed as incapable of meeting up to employment standards, or in need of more experience (Jammaers et al., 2016). These ableist and gendered expectations/requirements solidify patterns of exclusion for individuals who are unable to meet them, and may account for the challenges participants, at times, faced when attempting to get into work.

Where BPD was disclosed during the job search and selection processes, participants also experienced ableist responses, and were, in some cases, advised by job centres to go on disability benefits, seemingly due to reduced expectations of the capability to fit into the role of the ideal employee. Participants pointed to how selection processes can, for this reason, be subjective, or simply aimed at selecting an ideal (non-disabled) candidate (Sturm, 2001). The data, in this regard, supports the discussion in the literature review chapter (Section 3.3), on the exclusionary techniques employed by organizations during selection processes. Studies have largely referenced similar evidences of discrimination during recruitment/selection processes, due to either physical impairments or MHCs. Participants in Harpur's (2014) study, for instance,

experienced discrimination during recruitment procedures, due to impairment, while in Jones's (2005) study, BPD was found to impact on job prospects. According to Coleman et al. (2013), disabled candidates receive a call back for job interviews about 50 percent of the time, compared to non-disabled colleagues. Participants' experiences are, thus, largely reflective of extant literature, and further underscore theoretical considerations of the experiences of marginalization due to MHCs. As Biggs et al. (2010) suggest, employee selection techniques need to be assessed if progress is to be made with addressing the disproportionate representation of disabled individuals in the labour market, which continues to exist despite legislation such as the Equality Act 2010.

This sub-section places participants' experiences of the labour market within contextualized influences. Where previous studies have problematized disabled applicants, or focused on physical impairments, the section problematizes recruitment and selection procedures (Davidson, 2011), a theme that runs through the rest of the chapter. As aforementioned, the section addresses the first research question. Having examined participants' experiences of securing work/attempting to get into work, the next sub-section explores participants' experiences of maintaining work, particularly with regards to managing information about BPD, given it is an 'invisible' condition.

7.2.2 Maintaining work

All the participants of the study presented largely functional selves, rather than dependent selves, as may often be socially expected from individuals with MHCs (Boardman et al., 2003). Work formed a vital facet of participants' identities, particularly where workplace experiences were affirmative (Boardman, 2003; Borg et al., 2011). The study's findings are, in this regard, consistent with existing literature on the vital role of work for disabled individuals and the general populace (Waghorn and Lloyd, 2005; Kirsh, 2010). The significance attached to having a job may, of course, be related to the constructions of work as a major predictor for the quality of life amongst people. The 'employed' position has been made available via discursive processes, wherein employment is constructed as a major contributor to economic activity in wider society. This has resulted in the production of ideals, which can only be fulfilled where

one is in employment. Participants' narratives indicate the need to fulfil the ideals of being employed, and the majority sought to remain in employment. The particular benefits of work were, however, not a given, and several participants experienced diverse challenges in the bid to maintain work. These experiences were largely a function of the process of disclosure, as, where BPD remained undisclosed, the condition had little or no particular effect on the experiences of work or social relationships. Participants' experiences of disclosure are discussed in the following subsection.

7.2.2.1 Disclosure

The majority of participants' experiences of work were tied to the intricacies of having an invisible condition. Narratives ranged from different responses, to decisions on whether to disclose or not. Where participants disclosed at work, this was often linked to the need to be open about the condition, and present 'authentic' selves in the workplace (Kirsh, 2010). Participant A, for instance, refers to how it felt 'right' to disclose. Disclosure also occurred during manic episodes, or where participants felt secure and valued in the workplace. These findings are reflective of studies such as Brohan and Thornicroft (2010), where disclosure either occurred during episodes, or was directly related to a sense of job security. Dewa (2014) similarly suggests that people disclose either during periods where it may be difficult to keep the condition hidden, such as manic episodes, or where there is job security. Essentially, several participants indicated that they would disclose where they feel their job is secure and safe, but may be disinclined to disclose in the absence of job security, as disclosure is perceived to adversely affect job prospects. Participants' narratives suggest the need to demonstrate value in the workplace, and connotes that BPD individuals may need to settle for particular jobs where they can successfully demonstrate value, or be excluded from work which they would have excelled at due to the fear of the consequences of disclosing BPD.

The data underlines that disclosure can have both beneficial and adverse effects for BPD employees. On the one hand, for participants such as Participant G and H, it aided in securing work accommodations and support. For participants such as Participants D

and E, however, disclosure resulted in ‘micro-management’, surveillance, and the loss of career prospects. Again, existing literature on the experiences of disclosing an invisible condition supports this finding. Employees with MHCs have been known to experience more negative than positive responses (Wilton, 2006; Russel and Moss, 2013), unfair dismissals (Laxman et al., 2008; Hale, 2011), reduced career growth (Michalak et al., 2007; Von Schrader et al., 2013), and stigma (Dinos et al., 2004; Sajatovic et al., 2008; Lazowski et al., 2012) after disclosing at work. The majority of these studies focus on MHCs in general, or physical impairment; they, nevertheless, underscore how BPD may be produced within processes of disclosure as ‘difference’, due to the adverse connotations associated with the condition. Several times, participants demonstrated the fear of such responses, and did not disclose as a result. Non-disclosure for participants was largely related to concern with the possible adverse effects on career prospects, and the fear of the possible stigma or discrimination attached to disclosure (Peterson et al., 2011; Amsterdam et al., 2015). Participants seemed to enjoy the ‘advantages’ of being regarded as ‘normal’, and did not want to be perceived as different from the norm. Prior experiences also influenced disclosure decisions for some, with adverse reactions generating the tendency not to disclose in future work contexts (Clair et al., 2005). According to Goffman (1963), these inclinations are to be expected given that MHCs carry a stigma, and people with MHCs often experience exclusion. Delineations exist between such people’s social selves and that of non-disabled individuals. For this reason, BPD employees may be inclined to ‘pass’, or go to extreme lengths in order to keep the condition undisclosed.

The data suggests that such non-disclosure results in the lack of work accommodations (Wilton, 2006). Several participants had to apply coping techniques at some point, in order to maintain a non-disabled identity and challenge presumptions of inability. Participants adopted the social skills associated with impression management, indicative of what Hochschild (2003) terms ‘emotional labour’. This way, they were able to determine peoples’ views of them, while debating their disclosure decision. It involved either putting in extra work in order to meet normative standards, as found with Participant A, or adopting a ‘façade of normalcy’, as was the case with Participants A and B (Bertilsson et al., 2013). For other participants, it involved working overtime, or

assuming particular roles in order to deflect attention. Such techniques, however, had some adverse effects for participants, resulting in stress and burnout (Hochschild, 2003; Kumar et al., 2010). Maintaining separate selves was associated with some personal dissonance (Valeras, 2010), wherein participants expressed having the fear of being 'exposed' (Barnes and Mercer, 2004). Non-disclosure, therefore, came at a cost for participants. Participants' experiences, in this regard, are reflective of the discussion in the literature review (Section 2.3.4) on the experiences of emotional labour in the workplace. The decision not to disclose can be interpreted as indicative of the need to conform to workplace norms. As Goodley (2011) puts it, disabled employees, overtime, come to accept the suppositions of non-disability. They either assume the role of the submissive individual, appreciative of other people's 'care', non-problematic receivers of discriminatory responses (Zinn et al., 2016), or adopt skills for managing non-disabled selves in the workplace. Then again, given the post-structuralist perspective adopted, the decision to keep BPD undisclosed, and present as an 'ideal' employee, (thereby evading the 'disadvantages' associated with the label of BPD) can be interpreted as resistance of the subjective position of dependence often associated with MHCs.

It is, of course, vital to note that while non-disclosure may be beneficial for the positioning of participants within normative discursive practices, non-disclosure makes BPD invisible at work, and may inadvertently replicate or strengthen ableist practices (Williams, 2011). The ability to self-manage, naturally, depends on the degree to which participants attempt to adopt/present a self which conforms to established workplace discourse (Wilton, 2004). In essence, the success of participants' adopted identities is highly dependent on how representative they are of the ideal worker. Hence, by denying the BPD identity, participants may simply aid in maintaining ableist practices in the workplace (Amsterdam et al., 2015), leaving the normative context of work unchallenged. As Clair et al. (2005) put it, the resistance demonstrated via non-disclosure is largely micro-level, it benefits the individual while reinforcing collective normative discourse in the workplace. Conversely, being open and vocal about BPD may be one of the means for countering stigma and ableism in the workplace (Wilton, 2006). Acknowledging BPD in the workplace, and presenting as functional and

independent in the workplace may aid in repositioning the condition not only as accepted, but also supported within work contexts. Participants, such as Participant A, did seem to have little choice in deciding whether to accept the non-disabled identity or not, due to the somewhat inflexible nature of work in their workplaces. Normative standards in the workplace may, thus, leave BPD employees with little or no choice other than to present non-disabled identities at work, in order to maintain work. The workplace seemingly demands that disabled individuals refute their identity in order to thrive (Williams and Mavin, 2013). The decision not to disclose may, as a result, be a means for negotiating normative and inflexible work contexts.

One of the major factors found to influence participants' subjective positioning and disclosure decisions relates to the context of work. Contextual features contributed to the variations in meaning, and played a major role in the experiences of maintaining work (Wilton, 2006). The participants in specific work contexts seemed to find it easier to disclose than others. The data points to more acceptance/acknowledgement of MHCs in organizational discourse, particularly in MH support organizations, demonstrated through training programs aimed at developing the knowledge of MHCs. Such organizational contexts seemingly demonstrate resistance to the overriding discourse on MHCs, and broaden the concept of the ideal employee to encompass difference. Participants highlighted these contextual influences as reasons for the acceptance they experienced after disclosure. This is indicative of the pertinent role work contexts play in disclosure decisions, and in the overall experience of work. Such analysis of the impact of work contexts on BPD employees' experiences of disclosure is an under-researched area in disability literature. Indeed, while the 'side effects' of non-disclosure have largely been considered in literature (Wilton 2006; Peterson et al., 2011; Von Schrader et al., 2013), this study offers a more in-depth and nuanced perspective on how employees with invisible conditions may experience disclosure in the world of work. These findings, however, do not suggest an ultimate guide to when and where employees with the condition disclose, but point to the possible influence of context, underlining how it may be easier to disclose within particular work contexts than others (Wilton, 2006).

The analysis in this sub-section develops an understanding of the consequences of identifying with a concealed and disadvantaged subjectivity. The section highlights the vital role invisibility plays, and its contribution to the exclusion that BPD employees may or may not experience in the workplace. Participants' experiences are found to be intricately linked to the process of deciding whether to disclose or not within normative and unaccommodative organizational contexts, which disregard difference. According to Amsterdam et al. (2015), the absence of such choice results in an automatic label of difference; yet, disclosure renders the condition equally noticeable. Participants found non-disclosure beneficial, as they were able to evade exclusionary practices, and adopt non-disabled selves at work (Lingsom, 2008; Valeras, 2010). Presenting non-disabled selves, however, had adverse effects, and resulted in strain for many (Peterson et al., 2011). Participants were unable to access accommodations, and several faced difficulties with regards to acquiring skills for managing impressions/perceptions of non-disability, thus, underlining the dilemma BPD employees may face when deciding whether to disclose at work or not. Disclosure was, nonetheless, easier within organizational contexts that accept and support difference.

Having examined participants' experiences within the context of work in this section, the next sub-section explores the third facet of participants' experiences of work, that is, the experiences of returning to work after sick leave. Again, the sub-section directly addresses the first research objective: *To provide a longitudinal examination of the full range of BPD employees' experiences of work, including securing and maintaining employment, as well as returning to work after sick leave/career interruption.*

7.2.3 Returning to work

The majority of the participants of the study have taken time off work at some point due to BPD. The response of organizations, when resuming work, seemed largely dependent on the nature of the impairment for which participants went on sick leave. As a result, several participants sought to give reasons other than BPD when taking sick leave, citing reasons such as cold or flu, conditions they believe to be less stigmatizing, and less likely to harm their career prospects. Where participants cited these conditions, organizational response was largely minimal and nominal. Lelliott et al. (2008) and

Tjulin et al. (2011a) both had similar findings, whereby there was less stigmatized response for sick leave related to physical conditions than there was for MHCs. As Lelliott et al. (2008) note, employees returning from absences related to MHCs tend to have less favourable responses from colleagues, and from the organization as a whole compared to individuals with other impairments. Such variations in organizational response, according to Davidson (2011), highlight the need to narrow down research to focus on particular impairments/MHCs.

Regardless of the condition for which participants went on leave, the success of RTW procedures was found to largely rest on the organizational support offered to the returning employee. Participants' narratives suggest that resuming work is a more affirmative experience where there is adequate support, and it is easier to settle back into work where the workplace is receptive. In the instances where participants had adverse experiences, such as demotion and surveillance on resuming work, RTW proved to be a negative experience. The findings of the study are, thus, indicative of what is often recorded in literature on the relationship between RTW experiences and the level of support available in the workplace (Tse and Yeats, 2002; Williams and Westmorland, 2002; Tiedtke et al., 2010; Macaia and Fischer, 2015). This further highlights the vital role played by the context of work, and points to how restrictions to RTW may lay in the organizational/social response received upon resumption, rather than in the condition itself (Parle, 2012). As Macaia and Fischer (2015) succinctly put it, developing and sustaining workability is largely dependent on the context of work.

The first section of the chapter addressed the first research question. Emphasis was on exploring participants' experiences of securing/maintaining work, and resuming work after sick leave. Participants' experiences largely point to the normative structure of work in contemporary organizations, and underscore how work may be structured in ways which disadvantage employees with BPD. The next section examines the notion of normativity within the context of work.

7.3 Participants' experiences of work within normative contexts

This section discusses participants' experiences within work settings designed around non-disability. Two research questions are addressed: *How do BPD employees experience work, in settings intended for non-disabled employees?* and *What does the experience of BPD in the workplace indicate about the normative structure of work?* The aim, first, is to determine the degree to which work is constructed around non-disability and second, the degree to which organizations are willing to make adjustments to the structure of work in order to support 'difference'.

The research findings point to the inherently ableist processes found in organizations which may not recognize the legality of providing adjustments for BPD individuals. Several participants described the fast-paced nature of work, and the expectations of performance in their workplaces (Lysaghta et al., 2012). This could naturally present challenges for all employees regardless of difference. It, however, seemed to present added challenges for participants due to the need to retain some form of 'balance' for the sake of well-being. As Wendell (1996) suggests, the mental and physical differences of individuals unable to meet 'standard' expectations become visible and disabling, where they might have been unobtrusive and unrelated to full involvement within slower-paced contexts. The pace of work resulted in structural concerns and was disabling for participants, at times, contributing to manic episodes. This is representative of existing literature on the adverse relationship between normative work contexts and impairment (Williams-Whitt and Taras, 2010). The inter-relatedness between the pace of work and BPD in particular is, of course, largely under-researched. The need for work accommodations, however, often occurred due to such normative contexts. While participants demonstrated an awareness of their rights, and of the Equality Act 2010, none of them have employed the Act for securing adjustments at work. Some have, nevertheless, requested for accommodations at work.

The availability of accommodations seemed to vary on the basis of the type of work, and the degree of 'value' participants offered at work (Tremblay, 2008). Participants with accommodations were seen to relate the availability of accommodations to the value they added to work. These findings underscore the emphasis on optimizing the

value of labour in the labour market, and the notion presented is that in order to receive support, and in order for organizations to construct suitable work contexts, which may come at additional costs, BPD employees need to add value to the organization (Dewa, 2014). This may well be, given the changing nature of work, and the increased 'pressure' in contemporary workplaces to measure up to standards. As Jammaers et al. (2016) note, the evolution to a service economy has resulted in a reduced number of durable and permanent job prospects, and an increase in 'insecure' jobs. Value creation is increasingly a function of the degree to which organizations can exploit a flexible workforce. For this reason, it has become crucial that employees perform at maximum capacity (Fadyl and Payne, 2016). Where this is unattainable, BPD employees may be disadvantaged as a result, and accommodations may not be made readily available.

Several participants currently work without accommodations. This, at times, had to do with the inherent suppositions of non-disability in organizations (Hall and Wilton, 2011), which led to organizational perceptions of work accommodations as disruptive and different from the norm. Participants' narratives point to how BPD employees are expected to work optimally within the margins of the restrictions that exist in the workplace. This inflexible and narrow approach to work proved challenging for some. Again, existing literature supports this emphasis on the disabling effects of restrictive work contexts (Corlett and Williams, 2011; Williams and Mavin, 2012). The findings of this study, however, point to instances where the absence of accommodations was due to non-disclosure, or participants' own need to conform to normative means of carrying out tasks. The decision not to disclose particularly pertained in situations where work accommodations would have required working in a manner that deviates from the standard way of working (Williams and Mavin, 2013). Some participants were able to manage this successfully, due to the episodic nature of BPD. The episodic nature seemed to 'normalize' the condition, to some degree, in the workplace, with participants alluding to how, having worked long periods with non-disabled individuals, BPD had been normalized to some degree in their workplaces, and colleagues have hardly witnessed them during an episode. As Laxman et al. (2008) puts it, the episodic nature of BPD creates an organizational perception that BPD employees do not necessarily need as many accommodations as a physically disabled employee, for instance, would

need. Such normalization is often conceptualized in literature as valuable, as the invisibility of an impairment facilitates conformity with norms (Clair et al., 2005).

The implication, however, is that in the absence of formal workplace support, the organization comes to have standard expectations of BPD employees, which could place demands on such individuals (Amsterdam et al., 2015). Besides, interpreting the absence of support as means for normalizing disability due to participants' ability to manage work may be a one-dimensional interpretation. According to Williams (2011), where disabled employees are managed the same way as non-disabled colleagues, with specific suppositions of ability, impairment becomes imperceptible, and the validity of accommodative work settings is denied, which inadvertently encourages ableist practices in the workplace. Even where adjustments are made to the structure of work, Kulkarni and Valk (2010) argue that these only partly assuage the restrictions disabled workers experience, and may not contest ableism in the workplace. Participants, thus, seemingly limit their own autonomy, and encourage ableism in the workplace due to the disinclination to request for, or employ accommodations (Valeras, 2010). More importantly, the provision of accommodations is itself, reflective of medicalized/positivistic perspectives of impairment, given that restrictions are not eradicated before the disclosure of BPD (Kulkarni and Valk, 2010).

For the majority of the participants who did request for, and secure any form of accommodations at work, flexible working hours was often a priority. The following sub-section discusses this particular form of work accommodation granted to BPD employees.

7.3.1 Flexible working arrangements

Flexibility is one of the key means for enhancing BPD employees' experiences of the workplace (Tremblay, 2008; Coleman et al., 2013). Several participants of the study work part-time, and alluded to the vital role flexibility plays in their workplace experiences. Participants' narratives were, however, equally indicative of how particular standards regarding an 'ideal' employee who works full-time continue to be a part of the construction and ethos of contemporary organizations (Kmec et al., 2014). There is

evidence that employers continue to have expectations of far-reaching devotion to work, evidenced in the willingness to work long hours. This seemed to pertain even more to participants in professional and managerial positions, as was found with Participant B. According to Oladejo et al. (2012), such expectations of long working hours, particularly in high-level/managerial positions, aid in maintaining these positions for non-disabled employees. The expectations of long working hours seemed to prove disabling for participants, at times resulting in BPD episodes. In-depth analysis of such disabling effects of the pace of work on individuals with BPD is largely absent in literature.

Working part-time had other adverse effects for participants, particularly with regards to career progression. The majority have high level educational qualifications (postgraduate level), yet several work in mid-level positions, positions which are seemingly not proportionate to their qualifications (Lazowski et al., 2012; Dewa, 2014). This is suggestive of a disability-related glass ceiling effect, where employees are unable to attain higher-level roles in the workplace due to perceived deviations from the norm (Sturm, 2001). As often noted in disability and employment literature, work accommodations, such as flexibility, may create space in the workplace where specific achievements are perceived as more relevant than others (Foster and Williams, 2014). It is, of course, important to note that the participants of the study, at times, opted for less demanding positions, even where such jobs had less room for growth, due to personal subjectivity to the notion of BPD as incapability. This points to how particular jobs may be considered both by participants and the general populace as more suited to BPD individuals than others, again highlighting the normative construct of work, and its impact on subjectivity. In essence, BPD individuals may need to seek particular types of work in order to perform successfully in the workplace. The adverse effects of this are, however, evidenced in lower earnings and lower career prospects. The degree to which participants' subjectivities become compliant with the notions of incapability is further examined in subsequent sections of the chapter.

This section critiqued the conceptions of work organizations as neutral, and highlights discrepancies in the argument that work is constructed to suit everyone (Fadyl et al.,

2012), thus addressing the research questions noted above. The section points to the disabling nature of work, and underlines how differentiation occurs in the workplace due to the lack of accommodations, and the ableist nature of work (Williams-Whitt and Taras, 2010). As Williams and Mavin (2012) note, the contemporary nature of work is a key site for the constructions of impairment as ‘difference’ in contemporary organizations. However, having adopted a social relational approach, the study aims not only to highlight the significance and effects of the normative nature of work, but to also underscore how restrictive structures are produced within the context of work that limit not only what BPD individuals can do, but who they can be. As aforementioned, the social relational model does not solely highlight the disablement which occurs due to normative work contexts; it equally lays emphasis on how the constructions of an individual as different are sustained within social interactions, with resultant effects on the sense of self. The integration of the post-structuralist standpoint and social relational model in this study positions this impact on the self as occurring within the context of discourse. According to Coleman-Fountain and McLaughlin (2013), discourse shapes social relations, and establishes particular roles for people to take up on a daily basis. The study, therefore, considers social relations to both construct and be constructed within ableist discourse. The rest of the chapter considers this added perspective of the social relational model. First, the next section explores the specific discursive processes in the workplace that participants drew on, which have contributed to constructions of BPD as disability, and locates such discourse within wider discourse. This is subsequently contextualized within social interactions, and the impact on the ‘self’.

7.4 Workplace discursive practices and the impact on self

This section examines the discursive practices that influence participants’ narratives, and directly addresses the research question: *How are BPD individuals’ interpretations and experiences of work influenced by discursive practices in the workplace?* The aim is to discuss the specific discursive processes that have contributed to participants’ constructions of BPD, locating such processes within the wider discourse on disability. One of the major discursive practices participants drew on when narrating work experiences relates to the medical model. This is examined in the next sub-section.

7.4.1 Medicalized discourse

The data suggests that BPD and MHCs in general may often be interpreted from a medicalized perspective. BPD seems to be delineated as ‘difference’ via medical discourse, resulting in the categorization of participants as different, determining how they differ from the norm, and how they may return to being productive members of the society (Tucker, 2009). Participants are, for instance, diagnosed, and in the process of seeking/accessing help, have their experiences become medicalized. They seem to have little choice other than to engage in medicalized discourse when interpreting individual experiences. This is reinforced by the medical perspectives that continue to govern considerations of BPD, impacting on how individuals with the condition are received in the workplace, and influencing the conceptualizations of BPD in disability research (Vickerstaff et al., 2012; Marwaha et al., 2013). Such medicalized discourse was found to predominantly feature in the two narratives examined in Chapter six. Medicalism, however, results in perceived deviance, and the workplace is seen to individualize participants’ behaviour, inadvertently paying less attention to the social and discursive context of work. This is buttressed by the norms attached to behaviour in the workplace. Such medicalized notions inherently shaped the organizational response received by Clara and Ian (Coleman-Fountain and McLaughlin, 2013), resulting in the marginalization and ‘othering’ experienced by both participants. Aside from medical discourse, another major discursive influence found in both Clara and Ian’s narratives is the social discourse. This is considered in the following sub-section.

7.4.2 Socialized discourse

Participants constructed their experiences in relation to prevailing social discursive practices within particular contexts (Coleman-Fountain and McLaughlin, 2013). This often occurred from two perspectives. First, narratives were influenced by gendered discourse. There is evidence in both Clara’s and Ian’s narratives of how gendered roles may influence individual expectations. They seem to internalize gendered roles, with resultant effects on facets of work. Ian, for instance, chose to work full-time due to perceptions, at the time, of the role of men as breadwinners. He is seen to navigate a sense of self and construct meaning which frames the perception of self via such

discourse (Grant et al., 2004). The temporality of the discourse in question highlights the transitory nature of the 'self'. In essence, it indicates that the self may often be a function of available discourse; it may vary over time in relation to changing discursive contexts, and as a function of either acceptance or resistance of discourse (Mancini and Rogers, 2007).

Clara's narrative had similar gendered notions. She is seen to experience some exclusion due to choices regarding marriage and having children. Her narrative points to the continued expectations attached to femininity within the context of the UK, that of wife and mother (Ramsden, 2013), and highlights that gender may yet define/delineate acceptable behaviour in social spheres (Macaia and Fischer, 2015). The conception of motherhood as an essential facet of femininity often results in the constructions of female subjectivity, via the use of self-regulating and monitoring schemes, whereby women who deviate from the norm are left feeling inadequate (Riessman, 2000). This is evidenced in Clara's narrative where she underlines the normalcy of her siblings, who seem to have conformed to normative expectations. Her narrative is suggestive of the influence of such expectations on the constructions of the feminine sense of self/identity. As Coleman-Fountain and McLaughlin (2013) note, people often develop self-perceptions based on the experiences of socially constructed effects, such as the role played within the social context, standards/ideals, beliefs, social relationships, academic or social backgrounds. Gender emerges within these social contexts (Gibbs, 2005), and is performed when people interact with one another (Sabo and Gordon, 1995). Where societies do not make distinctions between the 'norm' and 'others', such delineations will have little or no social significance (Marshak and Grant, 2008).

The second social discourse in participants' narratives relates to ableism in the workplace. Non-disability is seemingly positioned as a necessity within the context of work (McRuer, 2002), and particular ways of being are accepted as the norm, principally with regards to normative behaviour. Such norms have become a part of the discursive framework in contemporary organizations, defining deviant behaviour based on compliance (Casey and Long, 2003). There is evidence at various points that both Clara and Ian are considered non-conformist, and as a result, less capable than their

peers. This is demonstrated in the reduced opportunities seemingly available to both participants. The responses received by participants at work were, themselves, largely influenced by stereotypical assumptions of reduced performance, and suppositions of difference (Amsterdam et al., 2015). These organizational responses replicate ableist discursive practices, resulting in the marginalization of individuals with BPD, and generally reinforce the ableist belief that everybody should be alike in terms of ability and attitude.

The discussion in this section directly addresses the research question: *How are BPD individuals' interpretations and experiences of work influenced by discursive practices in the workplace?* and highlights the major discursive practices participants drew on when narrating experiences of BPD. The two overriding discursive practices are in line with the models of disability discussed in the literature review (Section 3.2). This underlines the prevalence of particular discourse in disability studies. As aforementioned, the construct of non-disability as the norm within discourse is sustained and replicated via social relations. From a social relational perspective, social interactions play a major role in the replication of normative discourse in the workplace. The next section, therefore, places participants' experiences within the context of social interactions.

7.5 Developing the social relational model

This section examines how disability is constructed in the interface between work contexts and BPD; and in the relationships between BPD employees and colleagues, with resultant effects on subjectivity (Thomas, 2004b). The section merges Foucauldian analysis with the social relational model, and addresses the research question: *How can BPD employees' narratives contribute to an understanding of the social relational model?*

Social relationships played a vital role in participants' experiences of work. For the sole participant with a physical 'impairment' (in addition to BPD), social relationships were mediated via the power of the 'gaze'. The visibility of impairment is seen to impact on social relations for the participant, and there is evidence that she is immediately

assigned a dependent role, and relegated, to some degree, within social interactions (Von Schrader et al., 2013). She, for instance, narrates feeling out of place while shopping due to unsolicited offers of assistance. Reeve (2004) posits that this is to be expected, as where an impairment is visible, an individual may often be subjected to social suppositions of difference. For the participant in question, the ‘impairment’ became a major influence on social interactions, overriding/superseding other facets of the individual identity. Conversely, individuals with BPD may not undergo such experiences, except where the condition is disclosed to colleagues and superiors. Valeras (2010) does note that even in the absence of disclosure, individuals with invisible conditions often experience emotional strain due to the constant fear of being ‘discovered’. Besides, the interactions between an invisible condition and standard expectations (both gendered and ableist) seem to have placed particular strain on participants’ social relationships (Park, 2000). Such strain is demonstrated in Clara’s narrative where she discussed the difficult relationship with her family, due to what they seemingly perceive to be a deviation from gendered norms. Disability also occurred within social interactions for participants who disclosed at work. Disclosure of the condition impacted on relationships with line managers, in some cases resulting in micro-management, surveillance, and task restriction, ultimately limiting workplace experiences.

Such adverse organizational responses impacted on participants’ experiences of work, thus, underscoring the role of managerial relationships in either ‘enabling’ or ‘restricting’ BPD employees. As Martin (2013) puts it, employees with ‘impairments’ may ultimately be disadvantaged due to managerial responses. Aside from managers, relationships with colleagues also impacted on participants’ experiences of work (Snyder et al., 2010). BPD was found to impact on relations with colleagues, at times resulting in relationship breakdowns (Laxmann et al., 2008). The findings point to how the response from colleagues can have paternalistic tendencies (Jones et al., 2010), resulting in a sense of frustration for participants. Participant G, for instance, feels suppressed due to the care demonstrated by colleagues. Such reactions delineate BPD employees as the ‘others’ in the workplace (Reeve, 2002). Where employees felt differentiated, work was adversely affected. Participants’ narratives, thus, generally

highlight how disability may result within the context of relationships in the workplace. These findings are supported by extant literature which points to the vital role played by social interactions in workplace experiences (Tremblay, 2008; Corlett and Williams, 2011; Bertilsson et al., 2013). As Bertilsson et al. (2013) suggest, fitting in at work could, itself, be a vital contributor to performance and productivity. The analysis also offers a nuanced perspective on the particular means through which BPD employees may be disabled within the context of social interactions.

This section highlights the disadvantages which result from the interactions between employees considered ‘different’, and employees considered ‘normal’ within normative discursive contexts. The section demonstrates that disability may be replicated and sustained within organizational responses and social interactions at work, and underscores how social relations work to construct adverse implications for individuals considered the ‘others’. Normative standards were found to be upheld by colleagues and superiors, and dispersed via social interactions. In the process, ableist practices are replicated and sustained. Disability is taken to emerge within the context of such social interactions between BPD employees and non-disabled employees, interactions which result in the exclusion of BPD employees, but promotes and privileges non-disabled counterparts (Thomas, 2004b). As Williams (2011) put it, BPD employees may be dedicated to building a good career/performing optimally; however, the degree to which this will be successful is largely dependent on the nature of work and interactions with colleagues/managers, people who might not support such dedications/ambitions. The section has addressed the research question: *How can BPD employees’ narratives contribute to an understanding of the social relational model?*

The social relational model does not solely allow for consideration of how disability is replicated and sustained within social interactions. The approach also lays emphasis on how the social perceptions of an individual as different may impact on the sense of self. According to Reeve (2004), the effect on the sense of self is more disabling than either physical or structural barriers. As aforementioned, the study positions the impact on the self as a function of discourse. Merging the social relational model and Foucauldian post-structuralist perspective, the study posits that notions of difference are sustained

and replicated via discourse, and become imprinted upon subjectivities within social interactions. That is, subjectivity occurs within the discursive context of interactions between people constructed as ‘normal’ and those constructed otherwise. Hence, the analysis extends beyond the development of subjectivities, to explore the particular means through which subjectivities become influenced by discourse. The following sub-sections examine how subjectivities develop within discourse, and the operations of power from a Foucauldian perspective.

7.5.1 Impact of discourse on the self-positioning of employees

Participants did not only draw on discourse when narrating their experiences, a sense of self also seemed to develop on the basis of available discourse. This sub-section discusses how participants navigated particular self-positioning within discursive contexts in the workplace. The section directly addresses the research question: *How do BPD employees position themselves in the workplace?* From a social relational approach, the section underscores how restrictions may be placed on what BPD employees ‘can both do and be’ (Reeve 2004, p.3), via discursive means.

According to Campbell (2009), whether it be discourse related to the ‘rational man’ (in law), the ‘ideal citizen’ (in political theory), or the ‘normal physique’ (in science), any discourse underscores social constructions which infiltrate the very self, holding it hostage (p.10). In essence, the self is inseparable from discursive contexts. Participants’ narratives in Chapter six are indicative of how socially constructed discourse operates via social interactions, impacting on the self (Fadyl and Payne, 2016). Both participants’ sense of self seemed somewhat reliant on the stigmatized perceptions received from others, and the experiences they had within social relations. Clara, for instance, positions herself as different from her siblings due to perceptions of deviation from the norm. In such instances, where the manner in which an individual is perceived forms the basis of their identity, feeling accepted within social settings may be a vital contributor to a sense of self and self-image (Bertilsson et al., 2013). For this reason, and in order to be perceived positively, individuals who deviate may often submit to the social pressure to comply, as found in Ian’s decision to settle for a career he did not particularly take interest in. The development of these gendered subjectivities has been

considered to some degree in existing literature (Alvesson and Willmott, 2002). Collinson (2003), for instance, notes how work has come to be regarded as a vital means for ascertaining masculinity, and points to the degree to which men fixate on retaining a sense of masculinity, particularly within social contexts. Such studies affirm the vital role played by discourse in the development of subjectivities.

Subjectivity may, however, not always occur within discursive contexts. Clara and Ian both resisted prevalent discourse to some degree. Ian challenges prevailing means for managing BPD, which are essentially medicalized, drawing on less medicalized discourse in the construction of the self. He is seen to demonstrate this resistance via several means, including the decision not to request for work accommodations or take medications (Tremblay, 2008). Clara also demonstrate agency in parts of her narrative. The decision not to disclose in some workplaces, for instance, can be interpreted as the resistance of the subjective positioning of individuals with BPD as dependent and needy. The adoption of a façade in order to present a ‘normative’ self can also be interpreted as means for resisting the same positioning. Both participants, therefore, demonstrated resistance. They both seem to navigate positions of either acceptance or resistance within the context of available discourse. As Wright (2003) succinctly puts it, diverse discourse open up several subjective positioning, wherein individuals can self-identify and construe experiences. This did seem restrictive for participants of the study, evidenced in Clara’s narrative where she is seemingly presented with the singular alternative of aspiring for normalcy within the workplace. Participants, nonetheless, drew from such repertoires when attempting to understand and interpret their experiences (Wright, 2003).

Hence, rather than unveil the singular ‘self’, participants’ narratives point to diverse selves adopted on the basis of available positions within particular temporal discursive contexts. As Collinson (2003) notes, there is no sole identity, particularly from a post-structuralist perspective. The ontology of this study’s standpoint does question how participants come to acknowledge and present themselves as ‘subjects’ to such discourse (Tremain, 2005). Having adopted a Foucauldian approach, there is yet opportunity to consider the role of power in the development of subjectivities. The final

sub-section in this chapter discusses the Foucauldian influences found in participants' stories. Again, the section addresses the research question: *How do BPD employees position themselves in the workplace?*

7.5.2 Foucauldian techniques of power

Foucault proposes a form of ubiquitous power which is involved inherently in all forms of social relations. He highlights how this power/discourse operates on the self, marking and regulating it (Foucault, 1972). Some of the Foucauldian techniques through which such power operates are found in participants' narratives. Ian and Clara both experienced corrective and regulative measures in addition to surveillance measures within and outwith work. Ian, for instance, refers to being watched by colleagues, and having his mail intercepted. From a Foucauldian perspective, such processes of surveillance and objectification are aimed at constructing specific types of personalities. The hospital in Ian's narrative also creates a context for the objectification of Ian and other inmates, by treating them as 'patients' (Parle, 2012). They were seemingly asked to forfeit agency, and accept medicalized definitions of personal experiences, thus highlighting how such individuals may have their identities reconstructed via power influences, particularly via surveillance techniques. The repetition of lines and conformity to specific discourse by Ian and other inmates further points to Foucault's conception of power. According to Foucault (1982), power operates through such use of language. BPD individuals may come to understand themselves as 'disabled' within the context of these forms of discourse.

Aside from the hospital, both Clara and Ian experienced surveillance at work. Their experiences of surveillance are indicative of the use of social devices for ensuring conformity, and relates to the Foucauldian version of panoptic systems (Foucault, 1997). Power operates via these panoptive and corrective measures, impacting on people's subjectivities (Foucault, 1997). The impact of these power influences, as illustrated in Orwell (1950), is that individuals come to accept liability for the restrictions borne out of power; they become accepting of the power relations within which they find themselves. Panoptic systems can make people into disciplined objects of knowledge, who regularly examine personal conduct and outlooks to ensure they

conform to organizational ideals, resulting in a reduced sense of self, or subjectivities built on the notion of incapability as defined by workplace contexts (Foucault, 1982; Van Dijk, 2011). Surveillance is seen to have some cautionary effects both on Ian and fellow patients in the hospital, and on Clara in the workplace, evidenced in reduced career expectations, and the emphasis on self-perfection/measuring up to the norm. It is of course vital to note the role of resistance in both participants' narratives. In the absence of such resistance, there is no power (Foucault, 2000).

As aforementioned, this section addresses the research question: *How do BPD employees position themselves in the workplace?* The discussion highlights how subjective positioning occurs within discourse (Foucault, 1982), and the means through which the 'deviant' self is categorized, classified and reintegrated to fit the norm. From a Foucauldian post-structuralist perspective, the section underscores the argument in the third chapter (Section 3.5) on the operations of power through non-physical systems, such as the panoptic system and surveillance (Foucault 1997), which result in the production of particular subjectivities. It is vital to note that a sense of self often develops within the context of accepting or resisting these discursive systems.

7.6 Conclusion

This chapter discussed the findings of the study, and offers several insights. First, by addressing the research question, *How do BPD employees experience securing and/or maintaining employment?*, the chapter offers a nuanced and in-depth perspective on the experiences of BPD in the workplace, and contributes to knowledge of such experiences in disability literature. The second and third research questions point to how the experiences of BPD employees in the workplace may be a product of the construct of work around the ideal employee, one who is non-disabled (and male), while the fourth and fifth research questions turn the analysis 'inwards'. As aforementioned, the social relational model allows for consideration, not just of the restrictive structures which exclude BPD employees, but also the internalized ableism which impacts on personal constructs. Put simply, the model incorporates analysis of how restrictions may limit what BPD employees can both 'do' and 'be'. The analysis of these questions points to how employees may adopt particular subjective positions within available discursive

and temporal contexts. The final research question underscores how normativity is produced and sustained in the workplace via social relationships and interactions. The integration of the post-structuralist perspective and the social relational model allows for an exhaustive analysis of how ‘othering’ occurs within social relations. It becomes evident that, as Reeve (2004) suggests, colleagues, superiors, or even family members and friends can be the source of ableism. The analysis of the final question essentially attends to some of the critiques levied on the social model, such as the focus on the restrictive structures of the environment at the expense of what makes up such structures, and how they are produced/sustained within social interactions.

The findings of the study can be summed up in two major innovations. First, the findings highlight the disablist role played by the normative structure of work on the workplace experiences of individuals with BPD; and second, the findings underscore the influence of normative discourse on the sense of self within the context of work. These two facets of the findings, when merged, highlight the affiliation/interrelatedness between the ‘self’ and the discursive context of work. As Lewis and Simpson (2010) note, collective meaning and standards develop within discursive contexts with regards to, for instance, how employees should behave in the workplace. Such collective meanings develop into norms, and often become behavioural ideals, which may impact on the self. Employees, over time, come to internalize such normative constructs, with resultant effects on self-identity. From a social relational and post-structuralist perspective, this suggests that discourse does not only construct disability in the social domain, it equally constructs disability in the personal domain. In essence, by illustrating the influence of ableist work contexts on participants’ experiences and subjectivities, the study underscores the relationship between the self and discursive contexts.

The study adds a wider and deeper perspective to existing research on the social constructions of BPD. The perspective adopted underscores that the social connotations attached to the label of BPD, when allotted to participants, constructs such individuals as ‘less capable’. It allows for the dissemination of meaning to participants’ experiences, and opens up positions of subjectivity for these individuals (Mik-Meyer,

2016). The social contexts within which constructions occur have been highlighted as gendered and ableist, promoting the constructions of inability in discourse (Jammaers et al., 2016). This is seen to impact on participants' subjectivities, thus, highlighting that identity and the sense of self are unsolidified transitory concepts, socially constructed on the basis of available discourse. The interactions between discourse and identity is a pertinent area of analysis, given that the manner in which BPD employees' subjectivities develop within the context of workplace discursive practices is an under-researched area in disability literature. More importantly, these analyses affirm and strengthen the constructs inherent in the social relational model. The use of Foucauldian analysis for exploring the particular means through which the sense of self comes under the influence of power also aids in extending the theoretical basis of the model. The particular emphasis on social interactions, and on problematizing the work context, rather than individual capability differentiates the study from previous studies on BPD, and generates pertinent considerations for disability studies. The implications of these findings are further discussed in the next chapter of the thesis, which is the concluding chapter. The concluding chapter also discusses the degree to which the research objectives have been achieved, and the contributions of the research findings to both theory and practice.

Chapter 8 Conclusions

8.1 Introduction

This final chapter of the thesis provides a conclusion to the research. The chapter serves as a consolidation of the previous chapters, merging the themes discussed, and discussing possible limitations. It is structured as follows: first, the thesis is summarized in order to merge the research questions and the findings. The chapter then discusses the contributions and implications of the research findings, before assessing the possible limitations of the study, and proposing avenues for future research.

8.2 Research summary

As mentioned in the introductory chapter, BPD is largely under-conceptualized as a social construction within the context of social relational and organizational literature. There is a rarity of qualitative research on the means through which BPD employees are ‘othered’ within the context of work. This paucity connotes less visibility for the subjective experiences of BPD employees in disability literature. The current study offers an in-depth exploration of employment experiences, from the perspective of people living and working with BPD, underscoring the factors that aid or hinder employment, and how these are managed. By examining this, the study contributes to understanding how the construct of work affects the lived experiences of BPD employees.

Specifically, the research objectives include:

1. To provide a longitudinal examination of the full range of BPD employees’ experiences of work, including securing and maintaining employment, as well as returning to work after sick leave/career interruption.
2. To explore and provide in-depth interpretations of the lived experiences of BPD employees.
3. To explore the extent to which ableist physical/social aspects of employment affect employees with BPD.

4. To investigate the extent to which discursive practices in the workplace shape BPD employees' interpretations and experience of work.
5. To relate BPD employees' experiences of employment, to developing the social relational model of disability.

In order to achieve these objectives, the study engaged in an in-depth assessment of BPD employees' subjective experiences in the workplace, within the context of how work is structured. The introductory chapter begins the process by delineating BPD as a disability. The key themes that inform the thesis are underscored and linked to current interpretations of MHCs in the workplace. Subsequently, the particular subject area being researched is delineated, alongside the significance of researching BPD. The second chapter discusses the disadvantages disabled employees face in the workplace. The chapter presents a wealth of evidence, pointing to considerable gaps between the employment rates and experiences of disabled and non-disabled individuals in the labour market/workplace. The next chapter, Chapter three, examined the possible reasons for these disadvantages, with particular emphasis on the nature/context of work. The overarching aim of the chapter was to offer some theoretical background for understanding the experiences of BPD employees in the workplace. The chapter considered several perspectives on the constructions of 'disability' in relation to notions of 'normalcy' in the workplace, examining from a Foucauldian perspective, how 'disability' is produced around influences of power. The chapter also points to the possible intersections between disability and gender, wherein 'difference' connotes both disability and gender.

As noted in the chapter, this study adopts a different stance regarding the experiences of exclusion on the basis of 'impairment'. The study extends the social model in order to attain a social relational understanding of the socially constructed nature of disability. Impairment is taken as the raw material on which disability occurs; the facet of the body that has been socially constructed as 'deviance', which shapes social interactions. In the bid to comprehend the particular means through which social reactions are shaped, a post-structuralist perspective was adopted for theorizing the social relational model. According to Jammaers et al. (2016), this opens up room to explore the role played by

discourse in standardizing and maintaining notions of disability as ‘difference’. It allows for the exploration of the emergence of ‘disability’ within social interactions which are shaped by discourse, taking into consideration Foucauldian power influences. This theoretical stance informed the methodological and analysis chapters of the thesis. Given the emphasis on exploring the social constructions of BPD employees, the study is seen to take participants as the ‘producers’ of the knowledge. Semi-structured interviews were conducted with participants, the aim being to obtain their narratives on the experiences of work. The data collected was analyzed inductively, using narrative and Foucauldian analysis. It is argued in Chapter four that the selected techniques offer the best opportunity for deconstructing the discursive contexts within which notions of ‘difference’ emerge. Foucault’s analysis was used for deconstructing the socially constructed nature of disability, and analyzing the development of subjectivities within the interactions between power and discourse which delineates disability as ‘difference’.

The findings of the study point to how the discursive contexts of work have shaped and delineated disability as ‘deviation’ from the norm. First, Chapter five considered how ableism is produced and sustained within normative work contexts and social relations. The chapter highlights the normative nature of work in contemporary organizations, illustrating that the exclusion BPD employees experience may result from the perceptions of BPD employees as ‘different’ from organizational norms. Normative standards were found to be upheld by colleagues and superiors, and dispersed via social interactions, with the discursive contexts within participants’ organizations largely revolving around the assumed ‘inability’ of BPD employees. This suggests that the discursive contexts of work are shaped by the delineations of disability as ‘deviation’ from the norm. Such connotations are reproduced by discourse and considered as ‘facts’ within the workplace, which then go on to regulate employees’ behaviour. In essence, the discursive context of work may be moulded by individuals who replicate and draw on ableist discourse.

Participants received adverse organizational responses as a result of these negative connotations, and several experienced exclusion and ‘othering’ in the workplace, with resultant effects on the sense of self. This is evidenced in the second findings chapter

which deconstructs the discursive contexts of work within which participants are constructed as ‘different’, and depicts the role played by discourse in moulding participants’ experiences and subjectivities. The chapter underscores how organizational response and participants’ narratives may be shaped by wider discursive practices and Foucauldian power influences, with resultant effects on participants’ subjectivities. Specific discursive practices were found to be given priority over others within participants’ workplaces, particularly the medicalized discourse. As noted in Chapter three, such medicalized discourse aids in the delineation of disability as ‘deviation’ from the norm. The influence on subjectivities is evidenced in the positions of ‘acceptance’ and ‘resistance’ adopted by participants over varying temporal periods.

Both findings chapters generally contribute to Foucauldian research on the construction of subjectivities within ableist discursive practices, and develop further understanding of how power operates in the workplace via discourse, which impinges on employees’ constructions of the ‘self’. The findings affirm the fundamental suppositions of ableism in the workplace, and point to the normative nature of work in contemporary organizations, illustrating how the exclusion participants experience may result from the perceptions of BPD employees as ‘different’ from organizational norms. From a theoretical perspective, the findings also underscore that the notions of ‘difference’ are sustained and reproduced within workplace discursive contexts, and impinge on participants’ subjectivities via the means of social interactions/responses. Connotations within the workplace are seen to impact on participants’ sense of self, influencing both thought and subjectivity, which suggests that an employee’s identity may be as representative of prevalent discursive practices, as it is of any distinctive character/individuality.

Some of the key findings of the study are outlined below:

Suppositions of ‘non-disability’ are embedded in the very nature of work, and work is constructed in ways that are of less benefit to those who occupy bodies that do not fit into the ‘non-disabled’ category. Such constructions of work are evidenced in the visible and invisible ways through which organizations favour/support some attitudes and standards conventionally related to non-disability.
The experiences of BPD employees in the workplace are essentially a product of these normative constructs of work.
Normative notions are sustained and maintained in the workplace via social interactions. Ableism is, itself, produced, operates and is maintained within social interactions, and notions of ability/disability are constructs which result within social contexts and interactions.
Social interactions occur within broader discursive contexts. As noted earlier, social discursive practices impact on organizational understanding of MHCs, thus impacting on how employees and colleagues respond to BPD.
Discourse does not only shape BPD employees’ experiences of work; it equally impacts on the sense of self. Participants often adopted a sense of self on the basis of available discourse.
Such adopted identities are further enforced in the workplace through Foucauldian power influences. Foucauldian notions of panopticism and surveillance aid in reinforcing self-regulation and self-limiting behaviour, with resultant effects on the sense of self.

Table 8.1: Key research findings

8.3 Contributions to research and theory

As noted in Chapters one and three, the study attends to some of the critiques that have been levied on the social model, and some of the initial questions that remain unanswered by the model with regards to the experiences of social exclusion. By shifting emphasis to theorizing the adverse perceptions which exist in the workplace/society, and how these inform and maintain ableism in the workplace, the study addresses the critiques raised by scholars such as Shakespeare in 1994, where he argues that the pure materialist nature of the social model devalues pertinent influential factors including language and culture in disability analysis; and 1996, where he posits that analyzing the discourse of disability may offer a more multifaceted account of

‘disability’. The analysis of how social responses may reflect the representations and language of disability aligns the study with Shakespeare and Watson’s (2001) position on social identities being the products of social processes and discourses. The study, however, departs from the critical realist position adopted by Shakespeare and Watson in subsequent work. Rather than incorporate both the ‘body’ and the ‘social environment’, this study theorizes the adverse perceptions which exist in the workplace/society, and how these inform and maintain ableism in the workplace.

Essentially, the study critiques the biological essentialism of the medical model of disability/gender from a post-structuralist perspective. Disability is taken to be a social construct, enacted within discursive contexts. The Foucauldian post-structuralist perspective adopted aids in deconstructing the discursive contexts within which the connotations of disability as ‘difference’ have been shaped, as it is these that inform social attitude and behaviour. By underscoring and critiquing the prevalence of medical discourse in the workplace, the study shifts attention from medicalized discourse to ableist discursive contexts. The conceptualization of BPD adopted in this study, therefore, offers a valuable and different view to what is often adopted in disability studies. It becomes evident that the exclusion which BPD employees experience in the workplace is due to the context of work, rather than a function of discrete qualities, which is how BPD has been conceptualized in literature. This perspective develops on the basic constructs inherently found in the social relational model regarding the production of disability due to the limitations and restrictions which occur in the workplace, and contributes to an understanding of the social relational model.

The in-depth consideration of participants’ experiences of work also aids in developing a conceptual understanding of the elements of social limitations, and offers insight into the particular means through which BPD employees are impacted by such limitations. It is vital to note that this is a less researched area in Organization Studies and Business and Management literature. Studies in these subject areas continue to adopt the social model, and centre on the experiences of social oppression, with little attention paid to how such oppression is maintained and re-produced within social interactions. This

study, therefore, adds to an emerging body of work that employs disability literature for informing and influencing debates in Organization Studies.

The study also delineates the experiences of BPD from other MHCs, and highlights the manner in which the condition may be experienced differently by employees on the basis of how it is perceived and how work is structured. As Shakespeare and Watson (2001) note, each impairment generates a different response from the society. Physical impairments may, for instance, prompt particular reactions that invisible conditions will not. The same way, different conditions have varying inferences for the sense of self. The analysis in the study develops insight on the particularities of BPD within the context of how it is socially constructed and perceived. One of the probable facets that differentiate experiences of BPD from physical impairments is emotional labour as discussed next.

The study contributes theoretical insight into the experiences of emotional labour amongst BPD employees, an area that could be developed in future studies. The concept of 'emotional labour' is under-researched in Disability and Organization Studies. Indeed, according to Zinn et al. (2016), emotional labour is rarely considered in these subject areas. When considered, studies often pay attention to particular professions where interacting with customers plays a major role, such as the medical profession, lecturing, or call centre jobs (Liddiard, 2013). The study reveals the imperceptible emotional labour BPD employees may regularly engage in at work, in order to present 'employable' selves. This further points to the normative nature of work, and the standard expectations of performance which may exist in the contemporary workplace. Employees may often become subjective to these expectations, with resultant effects on the sense of self.

In relation to this, the study highlights the transitory nature of 'self', or what Thomas (2004c) terms the unsolidified and transitory nature of 'reality'. The sense of self is determined to be an unsolidified transitory concept, socially constructed on the basis of available discourse. The temporality of discursive practices results in a continued state of transition. This is a pertinent area of analysis given that the manner in which BPD employees' subjectivities develop within the context of workplace discursive practices

is an under-researched area in disability literature. More importantly, the findings affirm and strengthen the constructs inherent in the social relational model regarding subjectivity and ‘psycho-emotional’ disability. The emphasis on the particular means through which subjectivity to ableist notions occurs within discourse contributes to developing the theoretical basis of the model. From a social relational perspective, it becomes evident that the sense of self is largely reliant on the stigmatized perceptions received from others, and the interactions employees engage in within discursive contexts. That is, the manner in which an individual is perceived may form the basis of their identity. Where employees experience organizational responses which delineate them as ‘different’, they may submit to social pressure by, for instance, engaging in emotional labour in order to comply with standard expectations. The integration between such investigations of internalized ableism and the interactional nature of disability, itself, contributes to post-structuralist considerations.

Finally, the study increases the visibility of power influences, and reveals how the subjectivities constructed within discourse are inherently gendered and ableist. Theoretical insight is obtained on the discursive practices which operate in the workplace, within which the disabled identity emerges, and the ‘power’ such discourse has on the construction of subjectivities. It is, of course, vital to note that while emphasis is on how subjectivity occurs within discursive contexts; the study equally underscores the role played by ‘agency’ in participants’ experiences. The imposition of both gendered and ableist notions as investigative categories, nevertheless, aid in highlighting the development of subjectivities within discursive influences. The several factors that facilitate subjective positioning in the workplace, and the impact of such positioning on the work experiences of employees with a concealed, yet relegated condition are underlined.

These findings have broad inferences, particularly with regards to how MHCs are perceived and interpreted in contemporary workplaces and the society, given the continued increase in the number of people with MHCs and BPD in the UK, and the consistent constructs of MHCs as a ‘loss’ to organizations. As such, the study does not only offer a nuanced analysis of the lived experiences of BPD employees; it also offers

suggestions on how dominant structures and discursive practices can be made accommodative of difference. The implications of the research and possible recommendations are considered in the following section.

8.4 Implications for the constructions of disability in the workplace

The wider implications of the findings are likely to have value for the way work is structured in contemporary organizations. The study underscores that the ableist nature of work tasks employees with presenting employable selves. Employees naturally employ prevailing discursive practices in the attempt to present capable selves at work, resulting in the reproduction and maintenance of ableism. Having allowed for the perspectives of BPD individuals, the study opens up room for resistance. The suggestion that the context of work is the issue, not the 'employee' points to a different understanding of 'disability'. As Reeve (2002) notes, it is vital to highlight the significant role played by social relationships (and discursive processes) in the transition from 'BPD' (impairment) to 'disability', if BPD employees are to be accepted in the workplace, and the structure of work is to be challenged. This has theoretical significance, as it suggests that BPD employees can re-adapt individualized/medicalized discourse to produce affirmative selves.

It is also vital to note the role played by organizations in the experiences of BPD in the workplace. Disabled employees' experiences of work are often a function of organizational dedication to developing accommodative work contexts. To argue otherwise is to overlook the contributions of social mechanisms to the definition of disability. Participants' experiences, therefore, highlight the vital need for a change in the manner in which work is structured. As Barnes (1992) puts it, organizational studies need to pay more attention to the ableism found in contemporary social contexts, and the disabling effects of organizations. As such, work may be more accommodating if it is reconstructed or redesigned to comprise inclusive strategies, strategies which acknowledge the existence of norms and, thus, accept the reality of the notions of 'difference'. These would be strategies that are well-suited to diverse individualities, without necessarily supporting the organization of work in ways which benefit a particular group.

Having considered the possible implications and recommendations of the study in this section, the following section discusses the limitations of the study.

8.5 Limitations of the study

From a theoretical perspective, the study may be critiqued for the lack of attention paid to the ‘reality’ of BPD (Oliver, 2004). As aforementioned, similar critiques were levied on the social model by feminist and disability scholars who believed that the model dismissed the notion of impairment. However, the study does not deny the individual experience of BPD, rather it acknowledges it in terms of the materiality of discourse. The particularity of BPD as a ‘concept’ or as an experience is considered a construct of discourse. This connotes that participants have come to understand the condition as a ‘disorder’ via the influence of discourse. Thus, the existence of themes external to thoughts is not refuted; rather, the study suggests that themes cannot be established as themes outwith of discourse.

The study would probably have benefitted from a more intersectional approach, which underscores the interrelatedness between disability and gender. The emergence of gender in the study does add to the understanding of gendered relations, and points to the vital role gendered expectations play in the experiences of MHCs. This points to the possible benefits of employing gendered conceptualizations in future disability/BPD studies and research. In summary, the study addresses an under-researched area of analysis in disability studies, by highlighting the particular mechanisms through which BPD employees may be ‘othered’ in the workplace, and is, thus, pertinent to disability literature.

The selected research design also indicates that the study’s findings will have limited generalizability, as narrative techniques are often non-generalizable. This is more so given the number of participants recruited. Such implications can be interpreted as having consequences on the validity and reliability of the findings of the study. The research does explore a fraction of prevalent discursive practices within and outwith the workplace, and does not claim to have exhausted the study of discourse in ‘BPD and work’ studies. The narrative approach adopted is not aimed at making umbrella

conclusions, hence, the small number of participants recruited. Rather, the approach is aimed at contributing to existing knowledge of how BPD individuals experience work.

Another limitation that arose with regards to the data collection process had to do with time constraints. Given more time, the research could perhaps have been extended to take into consideration the experiences of different forms of 'impairments' within different discursive contexts in organizations in the UK. This may have offered more understanding of the socially constructed nature of specific impairments in relation to the discursive context within which they are located. Future research could conduct such analysis. Also, adopting a case-study approach which incorporates the experiences of disabled employees, their colleagues and line managers may have offered a more rounded view of the constructions of disability as 'difference' within the discursive context of work. This is particularly pertinent given that the study pays attention to the social interactions within which notions of 'difference' are reproduced and maintained. There may have, of course, been drawbacks to this approach; given that there will be employees who have not disclosed their MHC in the workplace, leaving the researcher with an incomplete view of the specific work context. It would have, however, added to the depth of the research.

Finally, the research design may also be critiqued for the lack of emancipatory techniques. As noted in the methodology chapter, disability scholars have largely been critiqued for having the tendency to objectify individuals with impairment without contributing to an improved understanding of the social exclusion such individuals experience (Foster and Fosh, 2010). This study does prioritize the insights obtained from participants' experiences of work, and it is expected that the findings will contribute to the move towards improving inclusion in the workplace. For this reason, the study is not exploitative. The next section examines the researcher's own subjective positioning in relation to the study, and the reflexive stance of the researcher, underscoring how personal values may have conflated with the data collected and the interpretations found therein.

8.6 Personal reflexivity

According to Riessman (2000), people approach research via the lens of individual connotations and interpretations. It is, therefore, imperative to reflexively consider preceding understanding and knowledge which pertain to a study, particularly for inductive research. This section contextualizes the research on the basis of the researcher's individual perspective.

The topic for this study, initially, was 'Disability in the Workplace'. The fundamental aim was to develop an understanding of the experiences of disabled employees in the workplace. I was drawn to the topic due to my experiences in the workplace. I had worked in the HR department of a Banking organization for several years, and during this period, I witnessed the disadvantaged position experienced by colleagues with MHCs. Several experienced both overt and covert discrimination, and were generally excluded, even within the social contexts of work in terms of social interactions with colleagues and managers. The adverse experiences were intensified in the few instances where their MHC became public knowledge. This developed my interest in the experiences of invisible conditions in the workplace. Having had a quick look through literature, I found that such adverse experiences and disadvantages were evidenced in literature. The interest to study disability in the workplace, therefore, grew from these experiences.

I do identify as a non-disabled, black female, which is why, as noted in the methodology chapter, I approached the interviews as the 'unknower', with participants positioned as the experts on the subject. I came to understand that there were perhaps some benefits to researching as an 'outsider'. It was helpful as participants seemed to want to break down every detail of their experiences when narrating their stories, given I was positioned as the 'unknower' in the interactions between us, which further enriched the findings of the study. This may not have being the case if I was disabled, as they may expect that I already have some idea of the experiences they have had in the workplace. It was also beneficial when it came to analyzing participants' narratives, as there probably would have been the tendency to impose my own experiences and values on the research - even more than I already did - if I was an 'insider'. Several participants

did want to know why I decided to do the research, and seemed re-assured once I explained my motivation for the study.

As above-mentioned, I am a black female. Over the process of the research itself, and while reviewing literature, I gradually gained an understanding of myself as, perhaps, also belonging to the category of 'difference', given that I reside in a society that not only delineates 'normal' as 'non-disabled', but also as 'male' and 'white'. I realized I could be considered the 'other' within some 'camps'. The impact this then had on the data collection and analysis process was perhaps the inclination to, at times, note the intersections that occurred between my experiences and those of participants, with regards to the disadvantages that arise due to the perceptions of 'difference' attached to specific social identities. I found that there was some proximity between participants' experiences and my own experiences of being positioned as 'different' on the basis of gender and race. It is, of course, vital to note that these positions are not similar, and may often be experienced in different ways. I, nevertheless, discovered points of similarities and dissimilarities in my own experiences of these 'disadvantaged' positions and that of the participants of the study. This often had to do with the experiences of covert adverse social responses. This did make me more conscious of how to go about interpreting the data, such that, even though my subjective positioning may influence the process, my personal experiences do not cloud my judgement.

The interview process, itself, was a learning experience. In order to enable participants have some flexibility in the narration of their experiences, I decided to use semi-structured interviews. Once my questions were prepared, I contacted different MHC organizations to aid in publicizing the research as discussed in Chapter four. This proved to be a long and tedious process, as I did not receive many responses to my mails. It took a bit of persistence and patience, but I was eventually able to recruit eight participants. I carried out repeat interviews with participants over the period of a year. The majority of the time between interviews was spent transcribing the interviews. This allowed me the benefit of cross-checking emerging themes with participants at subsequent interviews. The interviews worked out effectively, although they did get better and longer as I progressed, probably due to an increased familiarity with

participants and a growing knowledge of the field on my part. Some of the narratives of exclusion and discrimination were, at times, difficult to listen to. Participants' narratives did not, however, solely revolve around such adverse experiences. There were several stories of independence, resistance and self-assurance. I found this somewhat surprising, and upon reflection, realized that having read widely of the adverse experiences of disabled people in literature, I probably went into the field thinking that narratives will, for the major part, revolve around similar experiences. I quickly discovered this to not always be the case. To some degree, this seemed to challenge what was perhaps an unconscious supposition on my part. As a result, I had to re-assess my preconceptions, and make the conscious effort to not misinterpret participants' narratives as negative where they were apparently positive.

I did find it interesting that participants were comfortable using the term 'BPD', and several used terms such as 'mental illness'. For some, this meant accepting that the condition is a 'disorder' in need of medical management. For others, the adverse connotations in the terms seemed to have little impact on their sense of self. Such participants do not consider themselves as 'disabled'. They did not present BPD as being at the forefront of their experiences, and generally adopted an agentic position during the interviews. Across the three interviews, emphasis was often on their independence and capabilities. For these participants, the dissimilarities in the experiences of work between them and their non-disabled colleagues, then, seemed to largely be a function of the notions of 'deviance' attached to BPD, rather than as a result of the effects of BPD itself. This simply underscored, for me, the position taken in the study on the vital role played by language and discourse in developing and sustaining adverse social notions about disabled individuals.

Summarily, there are not many things I would have done differently, except, perhaps, to give more 'power' to participants. The research is, of course, not emancipatory, hence, this was not a requirement. And I carried participants along by cross-checking themes with them. But, this could have been a more comprehensive process during each of the interviews, where participants are given the opportunity to take out the parts they do not want included in the study. There may have been benefits to involving participants this

way, given that I approached the study as the ‘unknower’. As Clandinin and Connelly (2000) posit, adopting a ‘group’ technique for analyzing data, which involves parties such as the participants themselves examining the findings of the research may offer a more enriching research process. This notwithstanding, I hope that the study inspires further theorization of the experiences of ‘disability’ from the post-structuralist perspective, and aids in developing an understanding of the impact of normative constructs of work on employees who are perceived as ‘different’.

The next section offers recommendations for future research.

8.7 Future research

Several avenues exist for future research. As an extension to the focus in this study on the normative context of work, future research could investigate the experiences of MHCs within particular work contexts, particularly with regards to the level of preparedness and acceptance within contemporary organizations, and the impact this has on social and managerial response. Future studies may also consider the impact of MH awareness systems targeted at developing acceptance in the workplace, on prevalent ableist discourse. This may be with regards to specific MHCs, such as schizophrenia or post-traumatic stress disorder (PTSD). A more longitudinal approach could yield more variations in participants’ narratives, and offer insight into how identities are constructed within differing contextual influences. Furthermore, given that there has been little research on the degree to which BPD individuals engage with particular discourse in the attempt to build affirmative identities within the workplace, a more multi-faceted analysis of the discourse which operates in the workplace, and the identities that develop as a result may further highlight the social embeddedness of BPD employees’ workplace experiences. This can be examined within contexts other than the UK, in order to offer a more diversified perspective on the experiences of MHCs. A more gender driven approach to understanding the experiences of BPD may also offer new understanding of the social relational facets of the condition.

Research that considers the notion of a ‘transitory identity’ may also contribute to disability and organizational literature. This could, for instance, be in terms of how

people assume one identity in one context and another identity in another, or how employees may not be disabled in one work context where accommodations are provided and disabled in another, and how these identities interact with power influences. Other future research could pay more attention to organizational culture, and the wider socio-economic context. It may be beneficial to carry out similar analysis taking the wider socio-economic context into consideration in terms of, for instance, the current political milieu and the movement of people off of benefits. As it stands, employment/disability schemes seem largely targeted at minimizing the costs of disability benefits in the UK, and have been underlined by the notion of 'work over welfare'. This is rationalized as means for achieving equity and fostering the acceptance of 'difference'. Future post-structuralist studies could examine the discursive contexts that result from such policies, and the impact on disabled individuals both within and outside the workplace. Future studies could also consider the tensions that exist between acknowledging the materiality of the body and the constructionist perspectives of disability; or employ post-structuralist narrative analytical techniques for exploring the experiences of other social identities, for instance, the experiences of black women who have a 'diagnosis' of a MHC. There will always be room for such research which renders visible the relegation of the positions of 'difference'.

Finally, future studies could consider the 'language' of government policies. As noted in the study, language influences social awareness and shapes social contexts. It has considerable significance for the manner in which disabled individuals are perceived. The language used in employment policies, in particular, plays a major role, both in the individual experiences of work, and the degree to which the labour market will be accepting of difference. Studies that investigate the specific impact of such language and how workplace discourse draws on political language would contribute to organizational literature.

8.8 Conclusion

Several MHC policies have been introduced over the years, targeted at improving the experiences of MHCs in the labour market. At face value, the majority of the policies and initiatives have had some positive effects on the experiences of MHCs in the

workplace. Indeed, there have been vast improvements from the periods classified as the ‘asylum age’ in the 18th Century, to the ‘current age’ with regards to the experiences of disability in the workplace. It is, however, important to note that there still exists considerable gaps between the experiences of non-disabled and disabled individuals, both in the labour market and in the workplace. Individuals with MHCs continue to experience particularly high levels of disadvantage in the labour market. This is in spite of the general inclination amongst such individuals to work, and the existence of policies to facilitate this. This study suggests that the disadvantages may be due to the way work is structured in contemporary organizations. The position taken is that repudiating or belittling MH concerns within organizational contexts has adverse significances on employees, employers, and the general populace. Aside from creating awareness and acceptance in the workplace, it is vital that that BPD employees and employees with MHCs in general be ‘enabled’ at work. For this reason, emphasis in the study was on the process through which restrictive structures are created in the workplace, as inherent in the experiences of BPD employees. The emphasis on the constructions of normative structures in the workplace, and the role of ableism in the disablement of employees presents a different perspective to previous literature on BPD in the workplace. This positions the study within the context of theoretical attempts for understanding the impact of discursive definitions of ‘difference’ on BPD employee’s experiences of work. The study, therefore, contributes to a theoretically under-researched subject area regarding reasons for the exclusion BPD employees experience in the workplace.

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